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Staff from The Department of Labor and Industries, Office of the Medical Director (OMD) and The Crime Victims Compensation Program (CVCP):

- **Ken Crooker,** Fiscal Manager, CVCP
- **Valerie Estes,** Legislative, Policy and Program Outreach Coordinator, CVCP
- **Suzanne Gore,** Project Assistant, Mental Health Treatment Guidelines Task Force, OMD
- **Ryan D. Johnson, BS,** Administrative Support, OMD
- **Sandy Rains,** Administrative Assistant, OMD
- **Shellie Savage,** Administrative Support, OMD

Crime Victims' Compensation Program, Mental Health Treatment Guidelines Task Force:

- **Lucy Berliner, MSW,** Director of Research, Harborview, Center for Sexual Assault and Traumatic Stress, Seattle, WA
- **Martha Bird, MD,** Child and Adolescent Psychiatrist, Silverdale, WA
- **Charee Boulter, PhD,** The University of Puget Sound, Tacoma, WA
- **Carlos Carrillo, M.ED,** Department of Social and Health Services, Division of Children and Family Services, Yakima, WA
- **Jerry DeVore, PhD,** Director of Psychology Services, Good Samaritan Rehabilitation Center, Puyallup, WA
- **Steve Eckstrom, MSW,** Coordinator of Advocacy Services, Community Trade and Economic Development, Office of Crime Victims' Advocacy, Olympia, WA
- **Bev Emery, MA,** Executive Administrator, Community Trade and Economic Development, Office of Crime Victims' Advocacy, Olympia, WA
- **Gary Franklin, MD, MPH,** Medical Director, The Department of Labor and Industries, Office of the Medical Director, Olympia, WA

- **Monica Fitzgerald, BA,** Research Associate, The Department of Labor and Industries, Office of the Medical Director, Olympia, WA

- **Laura Groshong, MA, BCD,** Representative, Washington State Society of Clinical Social Workers, Seattle, WA

- **Lucy Homans, EdD,** Director of Professional Affairs, Washington State Psychological Association, Seattle, WA

- **Barb Huffman, MSW,** Program Manager, Compass Health, Sexual Assault and Sexual Abuse Project, Everett, WA

- **Tim Keller, MD, MPH,** The Evergreen Clinic, Kirkland, WA

- **Kara Laverde, MSW,** Training Specialist, The Casey Family Program, Seattle, WA

- **James Mahoney, MSW,** President, Washington Chapter of National Association of Social Workers, Spokane, WA

- **Orlando Manaois, LCSW,** Program Manager, The Department of Social and Health Services, Children's Administration, Olympia, WA

- **Cletus Nnanabu, MBA,** Program Manager, The Department of Labor and Industries, Crime Victims' Compensation Program, Olympia, WA

- **Loni Parr, RN, BA** Occupational Nurse Consultant, The Department of Labor and Industries, Crime Victims' Compensation Program, Olympia, WA

- **Lauren Slovic, MSW,** Project Manager, The Department of Labor and Industries, Office of the Medical Director, Olympia, WA

- **Hal Stockbridge, MD, MPH,** Associate Medical Director, The Department of Labor and Industries, Office of the Medical Director, Olympia, WA

- **Ted Rynearson, MD,** Medical Director, Virginia Mason, Separation and Loss Services Program, Seattle, WA

- **Muriel Templeton, MS,** Artemis Counseling Associates, Richland, WA

- **Carol Wood, PhD,** Psychologist Consultant, The Department of Labor and Industries, Crime Victims' Compensation Program, Olympia, WA

SUMMARY OF GUIDELINES

INTRODUCTION

For the past twenty-five years, victims of crime in Washington have been eligible to receive a variety of state benefits. The State Department of Labor & Industries administers this program, called the Crime Victims' Compensation Program (CVCP).

Many times, injuries from violent crimes are psychological, and can require some period of mental health treatment. The protocol for treating trauma can be complicated. For this reason, the state's Crime Victim Compensation Program Director began reviewing claims to see if there were any recognizable irregularities in the provision of services and utilization of benefits. In 1997, the Crime Victims' Compensation Program (CVCP) commissioned a joint research project with Harborview Center for Sexual Assault and Traumatic Stress and the University of Washington. Researchers studied the type and amount of mental health service used by Washington crime victims who sought CVCP benefits in 1994. As a result of the findings, the Mental Health Treatment Guidelines Task Force, a group of prominent mental health providers and representatives from the state agencies that provide services to crime victims was assembled.

WHAT THE RESEARCH FOUND

Of the 1781 crime victims using mental health benefits in 1994, 926 were sampled by the study. Of those, two-thirds, or 608 crime victims, were children under the age of 18, and the vast majority (88 percent) were victims of sexual assault. Among the 318 adults in the sample, 38 percent were victims of sexual assault and 40 percent were victims of physical assault.

While children received an average of 23 counseling sessions, and adults an average of 15, the average cost to the program was slightly less than $1,000 per claim. Few victims received long-term care or psychiatric inpatient care, though among both children and adults, sexual assault was the variable that most increased their use of mental health benefits. This is consistent with literature showing that sexual assault is the crime most associated with mental health consequences.

Researchers found that the mental health difficulties of crime victims were not always being carefully diagnosed. They also found the CVCP reporting requirements did not always yield useful information As a result, researchers suggested that there should be a method to encourage providers to perform comprehensive assessments and assign an accurate diagnosis (if a diagnosis is indicated), using *DSM-IV* criteria.

Finally, the research stressed the need for more accurate and useful state guidelines to help mental health providers understand the range of available psychotherapeutic and pharmacological interventions for treating crime victims.

TASK FORCE RECOMMENDATIONS

The task force determined that when crime victims first seek mental health assistance, it is essential to recognize that apart from any "disorder" that could be diagnosed, many simply need assistance coping with the aftermath of trauma. The first few steps a counselor takes to stabilize the victim of crime is often all that is required, though some clients will go on to seek additional sessions. In fact, research has shown that most CVCP claimants who seek mental health services do so on a relatively short-term basis, to help them through the first phase of coping.

For this reason, the task force decided that during these first critical counseling sessions, crime victims and their mental health providers should be free to focus on their acute needs and not on identifying a disorder or pathology to justify treatment. In fact, psychological trauma and a state of crisis is a normal and predictable result of violent crime.

The task force recommends that during the first six counseling sessions, the current safety of the child or adult crime victim should be the paramount concern, as well as assessing any medical, family or employment problems the client may be concerned about. It is important that clinicians not assign clinical diagnoses, such as Post-Traumatic Stress Disorder, simply because the client has been a victim of crime, and that these pathologies not become the basis for approval of benefits. Mental Health providers must first conduct a very thorough assessment and specific study of the patient's background before any diagnosis will be accepted by the CVCP. The task force acknowledged and incorporated the philosophy that not all crime victims have mental health issues. Many simply need assistance coping with the traumatic experience of victimization. For this reason, clients may receive up to six sessions before the program will require a *DSM-IV* diagnosis.

WHAT THIS BOOK CONTAINS

This book should clarify for you our specific guidelines on:

- What needs should be assessed when individuals in crisis first seek mental health assistance
- What steps you must consider when conducting your first therapeutic assessment
- How to formulate your diagnosis
- What specific documentation we will need from you for bill payment and authorization of sessions
- Information related to specific treatment issues e.g., Post-Traumatic Stress Disorder, Depression, Management of Complex Cases, Utilization of Interpreters, Provision of Culturally Competent Care, Use of Advocacy Services, Working with Clients with Disabilities.

In addition, this book contains references to many articles, publications and organizations that can help when you are evaluating victims of crime and their needs. These are not comprehensive lists, and the CVCP does not claim responsibility for information or services provided from these resources.

These guidelines are not intended to substitute for clinical training and supervision. Summaries of various diagnostic and treatment techniques are presented, but providers should not rely solely on these summaries in treating clients. Rather, providers should refer to manuals, textbooks, published research and other materials, and are expected to be fully qualified in whatever approach they use.

INITIAL RESPONSE, ASSESSMENT AND CVCP DOCUMENTATION PROCEDURES

The task force felt that claimants and service providers should be free to focus during the initial period of treatment on the acute needs and well-being of the victim, and not on identifying a disorder or pathology to justify treatment. Safety issues should be addressed immediately, starting in session one**.** ***(Guidance on safety issues is provided in Chart A on page 21.)*** For these reasons, the CVCP will not expect a specific diagnosis during the initial response phase of treatment (i.e., up to six sessions). During the first six sessions, all of the following domains should be assessed: crime related factors; significant medical, emotional/behavioral, social, and other factors; emotional/behavioral status; symptoms; time loss from work; resources (personal, family and cultural/religious). This assessment approach is summarized in Chart B on page 22.

ACCURATE DIAGNOSES

Clinicians must not assign clinical diagnoses, such as Post-Traumatic Stress Disorder, to a client based on the fact that the individual has been the victim of a crime. Clinicians should conduct a thorough assessment and study the *DSM-IV* criteria for specific diagnoses before determining which is appropriate. The CVCP recognizes all diagnoses as legitimate for treatment so long as the symptoms are related to victimization. For example, the victim does not need a diagnosis of PTSD for approval of a mental health claim. Clinicians should delineate differential diagnoses by the strict *DSM IV* (1994) criteria, and apply diagnoses only when full criteria are met.

DOCUMENTATION

If intervention requires six sessions or less, the Initial Response and Assessment form (Form I) must be completed. Form I appears on page 24.

When more than six sessions are necessary, Form II must be submitted no later than the sixth session. This full written assessment includes a diagnosis and treatment plan. Payment will not be provided for additional sessions until Form II is received. Form II appears on page 27.

By session 15 Form III (page 33) should be used to submit the Treatment Progress Note. Form IV (page 34) is used for authorization beyond session 30 for adults and session 40 for children. Form V (page 38) should be submitted for authorization beyond session 50 for an adult client, or session 60 for a child if additional sessions are being requested. Form VI is the Termination Report (page 42) and must be submitted on all clients at the time when treatment has been discontinued.

A flowchart summarizing the documentation requirements is provided on page 20.

CONSULTATIONS

Up to two consultations will be allowed without pre-authorization from the CVCP in the first 30 sessions for adults (40 sessions for children). An additional consult will be allowed without pre-authorization between the 30th and the 50th sessions for adults and the 40th and 60th sessions for children. Definitions and other information about consultations begin on page 18.

TREATMENT ISSUES

POST-TRAUMATIC STRESS DISORDER

A description of the current best practices for treatment of PTSD in adults is given on pages 56-58. This includes the four strategies that meet criteria for either "probably efficacious" or "well-established" treatment. These include: 1) Prolonged Exposure Therapy, 2) Cognitive Processing Therapy, 3) Stress Inoculation Training (SIT), and 4) Eye Movement Desensitization and Reprocessing (EMDR)

Tips are also given on pharmacotherapy for adult PTSD.

For children with PTSD, therapy techniques are described on pages 64-69. These include CBT techniques (such as stress management/relaxation techniques) and cognitive coping techniques.

DEPRESSION

A description of symptoms of depression and best practices for treatment are discussed. The most widely accepted diagnostic instruments are listed in Table 2 on page 82.

COMPLEX CASES AND CO-MORBID CONDITIONS

Suggestions for management of complex cases start on page 90. This includes co-morbid factors such as anger, anxiety, drug and alcohol abuse, and somataform disorders.

CULTURAL ISSUES

In responding to crime victims it is essential to acknowledge the circumstances and background of every victim. Important considerations include cultural context, ethnicity, and religious faith. In order to support clinicians in providing sensitive and culturally relevant services to crime victims, the CVCP will provide payment for consultations that focus on increasing a therapist's clinical understanding of the role and impact of cultural and social issues to an individual client. This is described on page 101. Resource addresses and phone numbers are given on pages 104 and 105.

UTILIZATION OF INTERPRETERS

When communication barriers prevent providers from understanding clients, effective care is impossible. Suggestions for utilization of interpreters start on page 106. A list of available resources is given on pages 111 and 112.

CRIME VICTIMS WITH DISABILITIES

When treating persons with disabilities, it is helpful to develop an understanding about their specific needs. Efforts should be made to facilitate access to therapy for victims who may have sight, hearing, or physical or cognitive limitations. Suggestions in this area appear on pages 113-116. Telephone numbers and addresses for resources are given on page 118.

ADVOCACY SERVICES

For many victims of crime, it is the partnership of services between advocacy and therapy that most effectively and quickly results in recovery from the impact of victimization. A description of advocacy services begins on page 119, including phone numbers and addresses of organizations that may be able to provide additional information.

APPENDICES

A sample safety plan for use with domestic violence victims can be found on page 123. Appendix B on page 129, provides a listing of literature that is relevant for providers, victims and their families. A list of statewide resources can be found in Appendix C on page 135. The biographies of Task Force Members can be found in Appendix D on page 136.

A. WASHINGTON STATE'S CRIME VICTIMS' COMPENSATION PROGRAM (CVCP)

1. HISTORICAL OVERVIEW

Washington's Crime Victims' Compensation Program (CVCP) began primarily as the result of a series of editorials in the early 1970's in the state's two major newspapers, the *Seattle Times* and the *Seattle Post Intelligencer*. The editorials' themes were that of the offenders having their room, board and medical needs met by the state's prison system while the victims were left with the medical bills and other expenses incurred as the result of the offender's crime.

In February of 1972, Pat Hemenway was walking in the arboretum at the University of Washington when a robber demanding her purse and confronted her at gunpoint. The robber shot Ms. Hemenway in the neck, leaving her paralyzed from the neck down. The first crime victims' compensation bill was filed in the 1973 legislative session, and given special impetus by the testimony from Ms. Hemenway from her wheelchair before the Senate Judiciary committee. Washington became, concurrent with Minnesota, the ninth state in the country to enact a victim compensation program. As a result of Ms. Hemenway's testimony, the bill contained retroactive provisions to January 1, 1972. Unfortunately, Ms. Hemenway died as a result of her wounds. Her benefits were paid to her surviving spouse.

The CVCP was created by the legislature in 1973 and became effective July 1, 1974. The program was placed within the Department of Labor and Industries because benefits were similar to workers' compensation benefits. Labor and Industries provided the administrative controls, trained personnel, and set legal precedents to manage benefits. The Crime Victims' Act, RCW 7.68, ties directly to Title 51 Industrial Insurance. However, there are significant differences in the eligibility criteria between the two programs. The CVCP is the payer of last resort. Victims must use public and private insurance first.

Through the years, several legislative changes have been made to the program. Many changes have expanded eligibility to cover additional crimes and make the program available to more victims. In July of 1981, caps were established on maximum benefits payable. In 1985, changes were made so that victims were allowed benefits even if the offender was a member of the family.

Program funding comes from the Public Safety and Education Account (PSEA) and from a federal grant for crime victim programs. The PSEA fund is made up of a percentage of revenues collected by the state courts and the legislature appropriates funds for crime victim programs from the public safety and education account. State statutes mandate the CVCP program to stay within the resources appropriated by the legislature.

2. BENEFITS UNDER THE CRIME VICTIMS' COMPENSATION ACT

BENEFITS FOR INJURED VICTIMS

- Medical and mental health services
- Time loss compensation (loss of wages)
- Permanent partial or permanent total disability
- Vocational rehabilitation
- Evidence gathering exams for sexual assault victims
- Counseling for family members of sexual assault victims

BENEFITS FOR FAMILY MEMBERS OF HOMICIDE VICTIMS (APPROVED BASED UPON CIRCUMSTANCES)

- Burial expenses
- Counseling for family members
- Pension if the victim was employed
- Lump sum if the victim was not employed

BENEFIT LEVELS

- $15,000.00 maximum for time loss
- $30,000.00 maximum for time loss, permanent partial disability (PPD) and vocational rehabilitation combined
- $40,000.00 maximum for pension
- $150,000 maximum for medical and mental health services

Note: The pension maximum is reduced by time loss, disability awards and vocational benefits paid.

CVCP does not pay for offender treatment.

HOW TO ACCESS BENEFITS

- A police report needs to have been filed within one year of the crime or within one year of the time when a report could reasonably have been made.
- An application for benefits must be received within 2 years of reporting the crime to police. The time period can be extended to 5 years with good cause. In the case of a minor, the 2 years does not begin until the individual's 18th birthday.

For more information about the CVCP please call (800) 762-3716

B. THE CRIME VICTIMS' COMPENSATION PROGRAM (CVCP) MENTAL HEALTH TREATMENT GUIDELINES TASK FORCE

1. PROJECT RATIONALE

In 1995, the manager of Washington's Crime Victims' Compensation Program (CVCP) decided to review the nature of claims to see if there were any recognizable irregularities in provision of services and utilization of benefits.

This review resulted in the realization that standards of care for mental health treatment in the CVCP program were lacking. The CVCP Manager began discussions with the Director of Research at Harborview Medical Center for Sexual Assault and Traumatic Stress about conducting research to assess the mental health service utilization by the State of Washington CVCP claimants. As preliminary data became available, it was evident that there was enough information to warrant creating the Mental Health Treatment Guidelines Task Force.

2. MENTAL HEALTH SERVICE UTILIZATION RESEARCH

OVERVIEW AND FINDINGS

In 1997, Lucy Berliner, Dr. Michelle New and Monica Fitzgerald of Harborview Center for Sexual Assault and Traumatic Stress, and the University of Washington conducted a research project at the CVCP. The study describes the type and amount of mental health service use by child and adult victims of crime who sought mental health benefits under the CVCP during the fiscal year (FY) 1994. Demographic, crime, psychological, and therapist factors were examined to determine their relationship to service utilization. The period of time over which costs and service use was calculated was from entry into the CVCP until data collection took place (January-May 1997).

The sample consisted of 926 crime victims out of the 1781 claims in FY 1994 of those sampled; 608 were children (under 18 years of age) and 318 were adults (including 33 "repressed memory" cases). Among child victims, sexual assault was by far the most common crime category (88%), while adults were most often victims of sexual (38%) and physical (40%) assault. Among the 33 "repressed memory" cases, almost all were victims of sexual assault.

On average, the median number of mental health outpatient sessions used by the 608 children was 23 sessions. For the 285 adults (excluding the "repressed memory" cases), the usage was lower with a median of 15 outpatient mental health sessions ***(see Table 1 on page 11)***. Overall, for both child and adult victims, the average cost to the program was slightly less than $1,000 per claim. There was, within each group, a range from a very few sessions to several years of therapy, but long-term treatment was an exception in this sample. Few victims received psychiatric inpatient care.

There were 33 claimants (1% of the total sample) who received mental health benefits for "repressed memory." The majority of these cases involved adults who had remembered earlier childhood sexual abuse experiences. As might be expected, these cases differed from other crime cases in that they generally involved long-term effects of experiences that took place in the distant past. It appeared that the psychological impacts among these victims were more complex and pervasive. This is reflected in the fact that they used significantly more outpatient mental health sessions (median = 59) than other crime victims.

TABLE 1: MENTAL HEALTH SERVICE USE BY ADULT AND CHILD VICTIMS OF CRIME			
Crime Victims	Range of Sessions Used	Total Median # of Individual Outpatient Sessions Used	Total Median # of Clinical Outpatient Sessions Used (includes intake, individual, family, group, pharmacological management, consultations etc., combined)
Adults (n = 285)	1 - 361	13	15
Children (n = 608)	1 - 249	17	23

Overall, the results revealed that demographic variables make a relatively small contribution to service use. Among children, ethnicity, gender, and socio-economic status were unrelated, only age predicted use, with younger children receiving more services. Since it is parents who take children to treatment, it is possible that they have heightened concern about their younger children and potential long term consequences. Socio-economic status was not related for adults, although women tended to have more service use and certain ethnic groups used less services. Among adults in general, women are more likely to seek mental health services. These data suggest that there are no systematic barriers to service use based on demographic characteristics.

The most important crime variable affecting use was whether a sexual assault occurred; adult victims who were sexually assaulted used significantly more sessions than claimants who were victims of other crimes (e.g., robbery, vehicular assault, homicide). On average, victims of sexual assault used 19 sessions (median value); victims of physical assault, including domestic violence, used 15 sessions; and those who were victims of other crimes used 9 sessions. These results are consistent with the literature that shows that sexual assault is the crime most associated with negative mental health consequences. Furthermore, offender relationship was not important among adult victims, but severity of the crime was; when a weapon was present, there was an injury, or the victim had Post-Traumatic Stress Disorder (PTSD), victims tended to have higher use.

Among children, victims of sexual assault used significantly more sessions (median = 24 sessions) than victims of other crimes (median = 17 sessions). Offender relationship was associated with service use; those children whose offenders were parents or parental figures used significantly more sessions (median = 28) than those in which the perpetrator was a non-related acquaintance (median = 18 sessions). This result is also consistent with the literature. However, duration and severity were not related.

Therapist variables made no contribution to length of treatment for children and adults. The therapist degree, gender, or location of practice were unrelated to service use. However, since the vast majority of treatment was provided by master's level therapists there was not much variability. These results suggest that there is no systematic bias among therapists in the amount of treatment provided.

Psychological variables were more difficult to interpret. Nearly 70% of both child and adult victims of crime received the diagnosis of Posttraumatic Stress Disorder (PTSD) and PTSD was associated with higher service use. It appeared that there might be a tendency for mental health providers to over use the diagnosis of PTSD in describing their clients' mental health problems. However, the diagnosis of PTSD may have been given as a reflection of the whole range of crime specific impacts on the crime victim, not just the *DSM-IV* diagnostic criteria of PTSD. This might explain the relationship of PTSD diagnosis to longer treatment use, because these are the individuals most harmed by the trauma, experiencing the most symptoms, and thus requiring more treatment.

It is important to emphasize that these data relating to mental health service use cannot be used to draw conclusions about the proper length of effective treatment for crime-related psychological consequences. The CVCP files did not contain systematic information regarding the mental health of the crime victim at the onset and termination of treatment.

RECOMMENDATIONS

The research findings suggested that the current reporting requirements for mental health treatment are not especially useful. In the review of charts, it was noted that the required reports were missing in many cases and the information requested and provided did not appear to capture the true picture of crime victims' psychological distress or clinician's treatment plan. Therefore, data being provided in the 90 and 180 day CVCP reports was insufficient for drawing conclusions about the proper length of effective treatment for crime-related psychological consequences. Furthermore, submitted 180-day reports were invariably approved for continued treatment and therefore may not be serving the intended purpose of outside, critical review.

It was recommended that the CVCP program establish a standard number of sessions that are allowed without requiring additional documentation. Claimants and providers could be informed that they are responsible for management of benefits within this range. The majority of victims would not use more than this number of sessions. For victims who request or require additional sessions, a two tiered procedure should be developed. This would mean that claims of victims seeking additional treatment sessions would be reviewed by a standing committee comprised of providers and claims adjudicators. Therapists would be required to submit a report containing explanation and justification of the request for additional sessions. In selected cases, where the request may be initially denied but protested by the provider or where previous extensions have been allowed, an Independent Mental Health Examination would be requested to determine whether additional treatment is indicated.

Recommendations from the research for treatment providers included the need for greater care and precision in the diagnostic assessment, requiring that providers adhere to the diagnostic categories and criteria contained in the *DSM-IV* and provide the supportive documentation when a diagnosis is made. Treatment plans should then reflect interventions that are effective or commonly used to treat the specific conditions that are identified. More careful attention to proper diagnosis may enhance the specificity of treatments that are delivered. This is not meant to imply that all aspects of the psychological consequences of victimization are captured by diagnosis, only that when a diagnosis is given it must be supported. Mental health provider documentation requirements should be changed to more accurately reflect the condition of victims and to provide useful information for adjudicators. The initial evaluation should include a diagnosis, supporting information about symptoms and level of impairment, pre-existing conditions, and treatment recommendations.

These recommendations are designed to promote better documentation of crime victim's psychological status, reduce unnecessary or inaccurate reporting by providers, and focus claims adjudicators on those cases requiring review instead of expending time on cases that do not require monitoring. It is anticipated that these changes in procedure and process would result in improved mental health care for victims, enhanced relationships with providers, increased accountability and more efficient administration of the program.

3. SELECTION OF TASK FORCE MEMBERS

The Medical Director at The Department of Labor and Industries appointed task force co-chairs; The Director of Research from Harborview and the Medical Director at Seattle Mental Health Center. In August of 1997, a Project Manager was hired and, shortly thereafter, task force members were recruited.

It was essential to compose the task force of individuals who were from as many regions in the state as possible. Efforts were made to recruit mental health professionals who represented a variety of disciplines and treatment approaches; worked with diverse client populations; and could represent professional organizations (e.g., The National Association of Social Workers, The Washington State Medical Association, the Washington State Psychological Association, the Washington State Psychiatric Association, and Washington State Mental Health Counselor's Association).

The Project Manager wrote to members of the mental health community as well as organizations that provided services to crime victims, introduced the project and asked for nominations for participants. In addition, some mental health providers had heard of the task force and submitted their resumes for consideration.

Thirteen mental health professionals were ultimately selected. In addition, seven individuals from state agencies that work with crime victims were also invited to participate. The agencies included: The Department of Labor and Industries, Office of Crime Victims Advocacy and The Department of Social and Health Services Children's Administration. Biographies of the task force members can be found in Appendix D on page 136.

4. TASK FORCE GOALS

The primary purpose of the task force was to define the range of psychotherapeutic and pharmacological interventions that are proven or recommended by scientific evidence and group consensus. Guidelines will enable clinicians to have an empirically informed practice, thereby providing quality mental health services to crime victims. Guidelines were developed with the philosophy that not all crime victims have mental health issues, but that many simply need assistance coping with the traumatic experience of victimization. This philosophy resulted in the decision that a client could see a provider for up to six sessions before a diagnosis was required by the CVCP.

The task force worked to create guidelines that fostered sensitivity to issues such as the victim's ethnic, cultural, and religious background, sexual orientation, and disabilities. The guidelines also encourage increased communication between CVCP staff and providers and collaboration between treatment providers and community resources.

Discussions that occurred at initial task force meetings illuminated that the regulations and rules of the agency can adversely affect how people diagnose and treat clients. Agency staff and clinicians agreed that some diagnoses such as Post-Traumatic Stress Disorder are overused. One theory about this was that providers seemed to be "diagnosing by crime" and by what they believe would be reimbursed versus paying close attention to diagnostic criteria.

INITIAL RESPONSE, ASSESSMENT AND CVCP DOCUMENTATION PROCEDURES

1. INTRODUCTION

When victims seek assistance, it is essential to recognize, that apart from any "disorders" that could be diagnosed, many victims of crime need and seek services from mental health professionals to help them cope with the aftermath of trauma. Initial contact with victims sometimes requires that the therapist provide crisis intervention to stabilize the victim. Steps taken in this phase can often be the extent of needed intervention though it can also lead to additional sessions. In fact, research has shown that most CVCP claimants who seek mental health services do so on a relatively short-term basis, to help them through the initial phase of coping.

Psychological trauma and a state of crisis are natural and predictable results of violent crime. Post-trauma often overwhelms the coping capacities of crime victims. It is reasonable that they should seek professional assistance when this happens. Claimants and service providers should be free to focus during the initial period of treatment on the acute needs and well being of the victim, and not on identifying a disorder or pathology to justify treatment. In the initial stages of treatment, it is sufficient to document with a report of injury, and a professional assessment that a claimant is experiencing a normal reaction to violence, threat of death, sexual assault, or the death of a loved one through homicide. If, at some point in the course of treatment, it becomes apparent that a specific disorder is present and should be addressed, a treatment plan can be developed.

In order to make diagnoses specific to trauma, it is important to collect information from a variety of sources and rely on results from multiple assessment methods (e.g., victim report, standard measures, observation). There are reliable, valid self-report measures and structured interviews that are cost effective, and do not require special equipment or much training to administer. A good assessment consists of a thorough synthesis of the information gathered.

Assessment should be an ongoing part of treatment. Symptoms and concerns may, and hopefully will, change over the course of therapy. As certain symptoms abate, other difficulties may emerge, such as problems not responding to a particular intervention. Victim priorities are a pivotal feature of engagement in the process. Therefore, assessment and treatment ought not be fixed; rather the focus should be refined and redefined as treatment progresses.

It is essential to acknowledge the individual circumstances and background of each victim. Many factors influence how people are affected by crime, such as their perceptions of how best to recover, and how they view institutions and mental health interventions. Among the important considerations are cultural context, ethnicity, and religious faith. There are different beliefs about how trauma, grief, death, and healing are best handled. The effectiveness of treatment may depend on the extent to which victims or their families see therapy as sensitive to, and consistent with, their values.

The age and cognitive capacity of victims is critical. Therapy should always be developmentally adjusted for children. Therapeutic responses should accommodate the cognitive level of victims. In cases of children and developmentally impaired adults, involvement of caretakers is especially important. Efforts should be made to ensure victims with sight, hearing, or physical limitations have access to therapy. Mental health professionals serving crime victims should strive to ensure that services are sensitive to individual differences and focus on the impact of the crime.

2. PURPOSE OF THIS GUIDELINE

The Crime Victims' Compensation Program (CVCP) Mental Health Treatment Guidelines Task Force has created guidelines to ensure that crime victims receive relevant, appropriate care. The following guideline was created to clarify:

1. The needs of individuals in crisis or in the initial stages of seeking assistance.
2. Steps to consider in conducting an initial therapeutic assessment.
3. Formation of a diagnosis.
4. Documentation expectations and bill payment.

Some crime victims do not require treatment beyond six sessions. The **initial response** is critical for education and support of victims of crime. The CVCP will not expect a specific diagnosis during the initial response phase of treatment (i.e., up to six sessions). **When more than six sessions are necessary, a full written assessment is required. This includes a diagnosis and treatment plan.**

An accurate diagnosis determines the treatment plan and approach used**.** All diagnoses are seen as legitimate for obtaining CVCP benefits if treatment that will be provided is related to the victimization. For example, the victim does not need a diagnosis of PTSD for approval of a mental health claim.

Clinicians should delineate differential diagnoses by the strict DSM-IV(1994) criteria, and apply diagnoses only when full criteria are met.

All clinicians are expected to keep informed of new developments in the field. The CVCP will not pay for ongoing clinical supervision. These guidelines are not intended to substitute for specialized training and ongoing supervision. The CVCP will pay for occasional case consultations as necessary and according to the parameters outlined in this guideline.

Clinicians MUST follow the documentation instructions presented in this guideline.

For information about the CVCP please call (800) 762-3716.

3. GUIDING PRINCIPLES

- Crime victims are individuals who may be in need of assistance as a result of a crime.
- Crime victims do not necessarily suffer from a psychological condition.
- Establishing a sense of safety and control for the crime victim is essential.
- All interactions require sensitivity to issues, such as the victim's ethnic, cultural, and religious background, sexual orientation or disabilities. Interpreters should be used when appropriate. ***(Please read the CVCP guideline on Utilization of Interpreters on page 106.)***
- A diagnosis is not required in order to provide an initial response (up to six sessions).
- A diagnosis should be based on documented clinical evidence that each criteria for a *DSM–IV* disorder is fulfilled for each diagnosis.

4. INITIAL RESPONSE

- Initial response refers to the **first six sessions** related to the crime and/or subsequent stressors (e.g., impending trial, offender released from prison).
- Initial intervention may serve as a form of early prevention that reduces the risk for subsequent problems.
- An initial response, as brief as one visit, may be sufficient for some victims to resolve the impact of the crime, or the crisis that precipitated contact with the clinician.
- Some victims may not desire formal therapy, or are not ready to begin therapy.
- Many victims rely on informal, natural, and social supports, or their own internal resources instead of formal intervention or as a compliment to formal intervention.

The initial response provides the opportunity for the crime victim and/or the parent/guardian of the crime victim to:

- Express feelings about the crime.
- Discuss the meaning of the crime.
- Receive support and validation.
- Learn about typical responses to traumatic events.
- Clarify the perceived need for treatment (e.g., what does s/he expect to achieve by seeking treatment).
- Express beliefs about culturally specific care.
- Identify personal, community, spiritual and system resources.
- Receive information about events and activities to occur (e.g., medical exams, the criminal justice system).
- Obtain information about community programs, including support and advocacy services provided by community sexual assault programs and domestic violence programs. ***(Please read the CVCP guideline about Advocacy Services on page 119.)***
- Learn about the treatment process.

The initial response provides the opportunity for the provider to:

- Listen actively and learn about the victim's experience and perceptions.
- Consider the victim's cultural beliefs.
- Be supportive.
- Establish a rapport and initiate therapeutic alliance.
- Assess immediate victim needs for medical care and safety.
- Consider the importance to the victim of alternative care (social, spiritual, medical).
- Reinforce positive coping responses.
- Provide information clients may need about resources and systems with which they might be involved (e.g., healthcare, domestic violence and sexual assault programs, the CVCP and the criminal justice system). ***(Please read the CVCP guideline about Advocacy Services on page 119.)***
- Formulate an impression of the victim's status and develop a diagnosis and treatment plan, if additional interventions appear indicated.
- Include family members or other support persons as appropriate.

To ensure client safety and prevent further traumatization and victimization during the initial response phase, it is <u>NOT</u> appropriate to:

- Extensively inquire about information regarding the trauma that was experienced.
- Conduct prolonged exposure therapy. ***(Please read the CVCP guideline about Post-Traumatic Stress Disorder that begins on page 45.)***
- Conduct sessions with both the victim and alleged offender present.

Notes:

- Sessions can last up to 90 minutes, including family or group sessions, and can occur more than once a week without pre-authorization.
- The CVCP does not pay for offender treatment.
- Therapists are mandated by law to report child abuse cases.

Please use Chart A on page 21 for guidance about the initial response.

5. ASSESSMENT

PURPOSE

An assessment is the gathering of information to:

- Determine impact of the crime.
- Formulate a diagnostic impression.
- Develop a treatment plan.

The process is a standard clinical assessment, where the primary focus is on the specific impact of the crime, not general impairment or diagnosis, per se. The impact of the crime also extends to events, reactions of others and system activities that result from reporting the crime. As with all assessments, attention is given to strengths and resources, as well as psychological symptoms requiring intervention. The information obtained from a thorough assessment can be useful to the CVCP in formulating decisions regarding authorization of additional treatment sessions.

DIAGNOSTIC ASSESSMENT

- Briefly summarize the essential features of the victim's symptoms, experience, vulnerabilities and resources that led to your diagnosis and treatment plan.
- Be sure to provide diagnoses in all five *DSM-IV* axes.
- Use the principles of differential diagnosis to:
    - Rule out drug abuse, medication or toxin exposure.
    - Rule out a general medical condition.
    - Rule out mood disorders.
    - Rule out malingering or factitious disorder.
    - Consider differential diagnoses to determine the accurate diagnosis.

Note: Other symptoms that may not meet full criteria but may be important.

SAFETY CONCERNS

To ensure victim safety, the offender should not be present during the initial interview and subsequent sessions.

- Clinicians should work with victims to develop a safety plan. ***(Please read the CVCP treatment guidelines appendix A, sample safety plan, page 123.)***
- If clinicians are unfamiliar with creating a safety plan, they should refer to therapists or organizations who can assist the victim. ***(Please read the CVCP guideline on Advocacy Services on page 119 and Appendix C, resources on page 135.)***

6. TREATMENT PLAN

The treatment plan should be developed in collaboration with the victim (include family and/or significant others for children) after assessment information has been obtained.

Include:

- specific treatment goals
- means for measuring progress
- treatment strategies to achieve goals
- auxiliary care (e.g., psychiatric evaluation, medication management, alternative care or other medical services)

Please use Chart B on page 22 to guide your assessment and assure that all important issues are addressed.

7. CONSULTATIONS

There may be instances when the client's emotional/behavioral status presents a diagnostic or therapeutic challenge. In such cases, you or the CVCP may refer the client for a consultation. It is the treating clinician's responsibility to obtain the client's consent prior to working with a consultant.

Consultations will be allowed:

- Without pre-authorization from the CVCP for two or less consultations in the first 30 sessions for adults (40 sessions for children).
- Without pre-authorization from the CVCP for one consult between the 30th and the 50th session for adults and the 40th and 60th session for children.

Consultations will not be allowed if:

- An independent medical health examination has been scheduled.
- Claim reopening is pending.
- The claim is closed.

Consultants must submit:

- A bill to the CVCP.
- A narrative report indicating the reason for the consultation and the recommendations resulting from the consultation.

8. PRE-AUTHORIZATION

The following treatment(s) require pre-authorization:

- Independent evaluation
- In-patient hospitalization
- Concurrent treatment
- Electroconvulsive therapy
- Neuropsychological evaluation
- Day treatment for seriously ill persons less than eighteen years of age
- Referrals for services or treatment not in the CVCP fee schedule
- Sessions beyond 30 and 50 for adult clients
- Sessions beyond 40 and 60 for child clients

Requests for authorization must be in writing and include a statement of:

- The condition(s) diagnosed.
- *ICD-9-CM* and/or *DSM-III-R* or *DSM-IV* codes.
- The relationship of the condition(s) diagnosed to the victimization.
- An outline of the proposed treatment program, its length and components, procedure codes and expected prognosis.

9. PAYMENT OF BILLS AND DOCUMENTATION REQUIREMENTS

SESSIONS 1-6

- If intervention requires six sessions or less, Initial Response and Assessment: Form I must be completed. ***(See page 24.)***
- If the victim will seek treatment for more than six sessions, it is **not** necessary to complete Form I. Form II **must** be submitted no later than the sixth session. Payment **will not** be provided for additional sessions until Form II is received. ***(See page 27.)***
- Form II must be completed even if the clinician has seen the victim for more then six sessions prior to filing the CVCP application for benefits (e.g., in cases where CVCP is the secondary payer or where a claim was not filed immediately).
- If there is indication that the initial response and assessment are expected to take longer than six sessions, due to extenuating circumstances, documentation **must** be provided to CVCP explaining the situation and requesting authorization for an extended number of sessions.

SESSIONS 7 AND BEYOND

- Submit the Treatment Progress Note: Form III at session 15. ***(See page 33.)***
- Form IV must be submitted for authorization beyond 30 sessions for an adult client, or 40 sessions for a child. ***(See page 34.)***
- Form V must be submitted for authorization beyond 50 sessions for an adult client, or 60 sessions for a child. ***(See page 38.)***
- The Termination Report: Form VI should be submitted on all clients at the time when treatment has been discontinued for any reason. ***(See page 42.)***

SURVIVORS OF HOMICIDE VICTIMS

- When treating family members of homicide victims, please submit required reports for each family member seen in treatment.

Note: Payment for any treatment is dependent upon acceptance of the CVCP application for benefits and timely submission of required reports.

THE CVCP CLAIM PROCESS

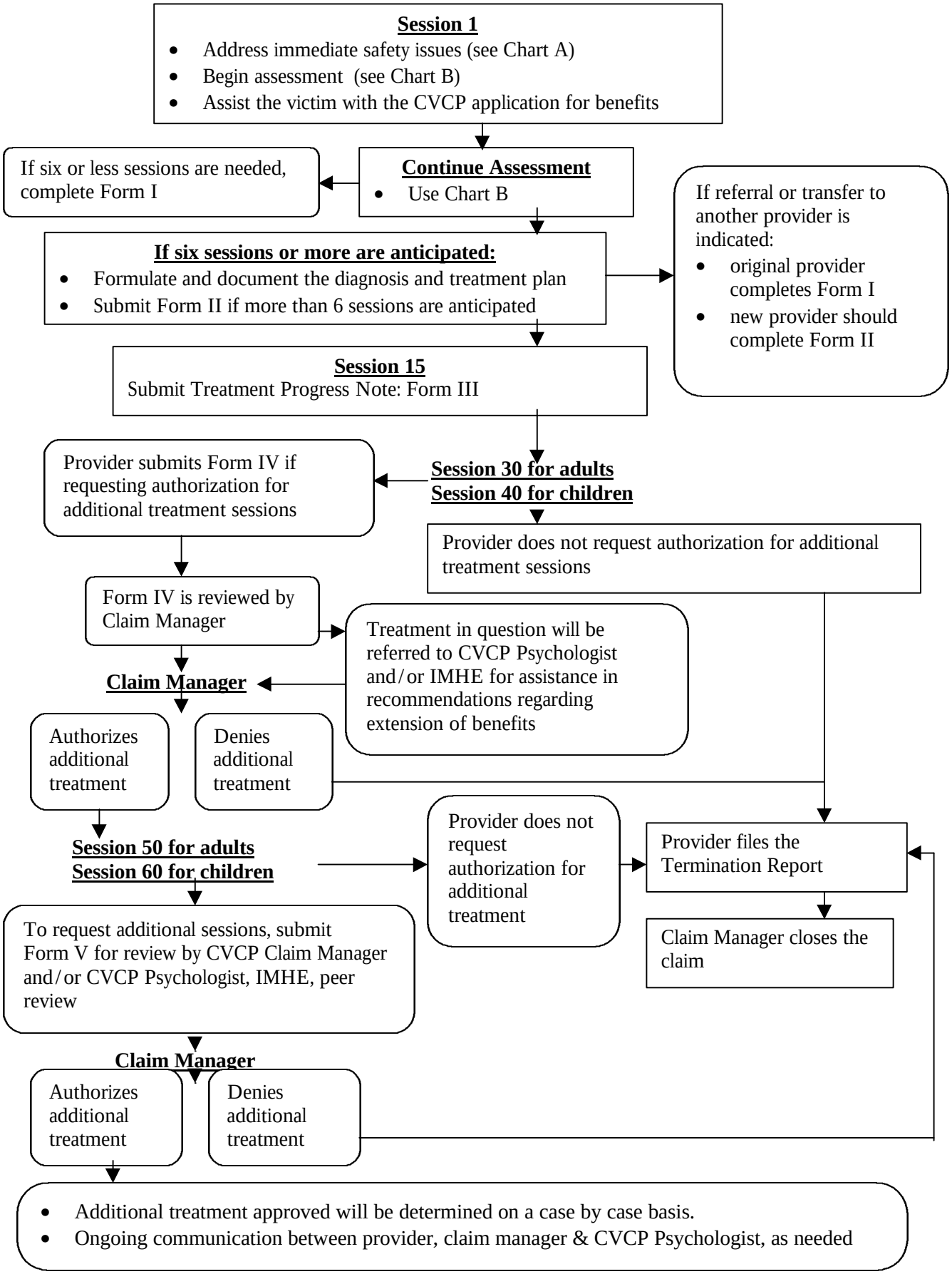

CHART A: TOPICS TO ADDRESS IN THE INITIAL RESPONSE

(Sessions 1-6)

Immediate Safety Issues:

- Need for crime related medical attention
- Need for other medical attention such as consultation for psychotropic medications, treatments from spiritual, or faith healers
- Danger to others
- Safety of living arrangements (e.g., offender access)
- Housing/shelter needs
- Financial needs
- Referral to domestic violence or sexual assault programs for support, advocacy, safety planning, housing and financial needs. (***Please read the CVCP guideline about the use of advocates on page 119.)***

Therapist Responsibilities:

1. Contact protective services and/or law enforcement for child or adult dependent abuse and/or neglect cases.
2. Warn potential victims when your client is threatening others (Tarasoff, 1974 duty to warn).
    - Inform the victim that CVCP eligibility requires that the crime be reported to law enforcement within 12 months.
    - Obtain written informed consent for treatment, including client disclosure.
    - Obtain applicable releases of information if the client is requesting that the clinician have contact with another party, or if contact will be necessary in the future.
    - If intervention requires six sessions or less, no paperwork is necessary **except** Form I. If more than six sessions are expected, Form II must be completed.
    - Explain to victim the standard number of sessions allowed by the CVCP.

Time Loss from Work:

- Is the victim unable to work due to the effects of the crime?
- What are the specific dates of his/her disability?
- What is the estimated date of return to work?

CHART B: TOPICS TO ADDRESS IN THE INITIAL RESPONSE AND ASSESSMENT PHASE

(Sessions 1-6)

ASSESS THE CLIENT IN ALL THE FOLLOWING DOMAINS

1. Crime Related Factors:

- Description of the victimization
- Resulting physical injuries/conditions
- Severity of injuries
- Perceived threat of injury or death during the crime
- Chronicity of the event(s)
- Meaning of the event(s) to the victim (with children, clinicians may interview the parents, family members and other significant adults about the meaning to them)
- Legal issues (Is the crime being prosecuted?)

2. Significant Medical, Emotional/Behavioral, Social, and Other History:

- Prior or current emotional/behavioral conditions, treatment history and response to treatment
- Current and past medical concerns including current medications
- Substance abuse history and related treatment history
- Relevant health care victim has received including hospitalizations
- Family history of emotional/behavioral conditions and treatment history
- Pre-crime level of relationship/social/school/occupational functioning
- Other current victimization, including witnessing domestic violence
- Past victimization or violence e.g., physical/emotional/sexual abuse/violence, including in the client's homeland if a refugee/immigrant

3. Emotional/ Behavioral Status:

- Appearance/ behavior
- Evidence of thought disorder/psychotic thinking
- Suicidal/homicidal ideation
- Ability to discuss crime related content
- Emotional state

4. Symptom Checklist:

- Aggression
- Anger
- Anxiety
- Apathy
- Avoidance
- Behavior problems
- Compulsive behavior
- Crying
- Denial
- Depression
- Difficulty concentrating
- Disordered eating symptoms
- Dissociation
- Emotional numbing
- Fear
- Flashbacks
- Guilt
- Harm to others/threats to others
- Hyperarousal
- Insomnia/sleep problems
- Irritability
- Memory problems/hyper-arousal
- Nightmares
- Obsessive behavior
- Panic
- Phobias
- Self-blame
- Self-destructive relationships
- Self harm behaviors/impulses
- Sexual acting out
- Sexual dysfunction
- Somatic complaints
- Substance abuse withdrawal

5. Time Loss from Work:

- See bulleted items in Chart A on page 21.

6. Resources:

Personal

- Self awareness/insight
- Self esteem/self acceptance
- Perceived sense of control over life events
- Economic resources
- Social supports (groups, church, etc.)

Family

- Immediate
- Extended

Cultural/Religious

- Religious/spiritual orientation
- Cultural differences and supports
- How are traumatic experiences and victimization handled?
- How is therapy and help seeking viewed?
- If the crime victim is of a different culture than the perpetrator and/or the therapist, how does it affect the meaning of the trauma and therapy?
- How do parents interact with children who are emotionally or physically hurt in their culture?

REFERENCES

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington D.C.: Author.

Crime Victims' Compensation Program. (1999). Mental health treatment guidelines. Olympia, WA: The Department of Labor and Industries.

Tarasoff v. Regents of the University of California. (1974). 529 P2d 553. 118 CalRptr 129.

RELATED READING

CRISIS RESPONSE

Roberts, A. R. (ed.). (1995). Crisis intervention and time limited cognitive treatment. Thousand Oaks, CA: Sage Publications.

Spungen, D. (1998). Homicide: The hidden victims: A guide for professionals. Thousand Oaks, CA: Sage Publications Inc.

ASSESSMENT

Briere, J. (1997). Psychological assessment of adult posttraumatic states. Washington, DC: American Psychological Association.

Carlson, E. B. (1997). Trauma assessments: A clinician's guide. New York: Guilford Press.

First, M. B. (1996). Practical applications of DSM-IV in a managed care environment, Volume I: Managed care, Volume II: Differential diagnosis, Volume III: Multiaxial diagnosis. North Towanda, NY: Multihealth Systems.

Please refer to each CVCP guideline for topic-specific readings and to appendix B on page 129 for a general bibliography.

Submit this document to:
Crime Victims' Compensation Program
Department of Labor & Industries
Post Office Box 44520
Olympia, Washington 98504-4520

CVCP Initial Response and Assessment: Form I

Please submit this form if you are seeing the victim for **six sessions or less**. If you will provide more than six sessions, please complete Form II. Payment for treatment provided will also be dependent upon the processing and approval of the CVCP application for benefits.

BILL PROCEDURE CODE 0122C FOR THIS REPORT.

Victim's Name		CVCP Claim Number
Client's Name (if different then the victim's)		Date treatment began
Clinician's Name	Clinician's Provider Number (if known)	Number of sessions to date
Clinician's Address		Clinician's Phone Number ( )
City		State Zip+4

Please review the CVCP guideline on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) What is the victim's or caregiver's initial description of the crime incident for which they have filed a CVCP claim? If the victimization was not recent, please describe what brought the victim into treatment at this time**.**

Turn page to continue

2) What are the victim's presenting symptoms/issues (by your observation and client report)?

3) Has the victim experienced time loss from work as a result of this victimization?

- ❑ No
- ❑ Yes; Please list the date(s) the person was unable to work and if applicable, give an estimated date of when the individual will return to work. Please explain why the time loss has occurred, the extent of impairment and the prognosis for future occupational functioning.

Dates:

Explanation:

Turn page to continue

4) What type of intervention(s) did you provide?

Submit this document to:
Crime Victims' Compensation Program
Department of Labor & Industries
Post Office Box 44520
Olympia, Washington 98504-4520

CVCP Initial Response and Assessment: Form II

Please complete this form if you are seeking authorization to provide more than six sessions. Payment will not be provided for additional sessions until Form II has been received. The CVCP application for benefits must also have been processed and approved.

BILL PROCEDURE CODE 0123C FOR THIS REPORT.

Victim's Name		CVCP Claim Number
Client's Name (if different then the victim's)		Date treatment began
Clinician's Name	Clinician's Provider Number (if known)	Number of sessions to date
Clinician's Address		Clinician's Phone Number ( )
City		State Zip+4

Please review the CVCP guideline on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) What is the client's or caregiver's initial description of the crime incident for which they have filed a CVCP claim? If the victimization was not recent, please describe what brought the victim into treatment at this time.

Turn page to continue

2) Briefly summarize the essential features of the victim's symptoms, related to the crime impact, beliefs/attributions, vulnerabilities, defenses and/or resources that led to your clinical impression (Refer to the DSM IV and CVCP guideline on Initial Response, Assessment and Documentation Procedures.):

3) Please describe pre-existing or co-existing emotional/behavioral or health conditions relevant to the crime impact if present, and explain how they were exacerbated by the crime victimization (e.g., depression, anxiety, vulnerabilities in personality structure, etc.).

Turn page to continue

4) List diagnoses on all 5 Axes ***(be certain all diagnostic criteria are met).***

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V/ Current GAF:
Highest GAF past year:

5) Treatment Plan (based on diagnosis and related symptoms, see the CVCP guideline on Initial Response, Assessment and Documentation Procedures)

A. What are the specific treatment goals that you and the victim have set? Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant other.

Turn page to continue

B. What are the treatment strategies to achieve these goals?

C. How will you measure progress toward these goals?

Turn page to continue

D. Describe auxiliary care that will be incorporated (e.g., psychiatric evaluation, medication management, spiritual healers, community services or other services).

6) Please describe your assessment of the victim's treatment prognosis, as well as any extenuating circumstances and/or barriers that might affect treatment progress (e.g., previous trauma history, pre-existing emotional/behavioral or medical conditions, family and social support system response and dynamics, religious/spiritual beliefs, cultural practices, involvement in criminal justice system or proceedings involvement with Child Protective Services, etc.).

Turn page to continue

7) Has the victim experienced time loss from work as a result of this victimization?

- ❑ No
- ❑ Yes; Please list the date(s) the person was unable to work and if applicable, give an estimated date of when the individual will return to work. Please explain why time loss has occurred, the extent of the impairment and the prognosis for future occupational functioning.

Dates:
Explanation:

Submit this document to:
Crime Victims' Compensation Program
Department of Labor & Industries
Post Office Box 44520
Olympia, Washington 98504-4520

CVCP PROGRESS NOTE: FORM III

This form should be completed after session 15. This form is a reminder that you are halfway through the authorized number of sessions. You should begin to consider whether or not you will need more than the allotted 30 sessions for adults/40 sessions for children, and the rationale behind the need.

BILL PROCEDURE CODE 0124C FOR THIS REPORT.

Victim's Name		CVCP Claim Number
Client's Name (if different then the victim's)		Date treatment began
Clinician's Name	Clinician's Provider Number (if known)	Number of sessions to date
Clinician's Address		Clinician's Phone Number ( )
City		State Zip+4

Please review the CVCP guideline on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) Is there substantial progress toward recovery from the crime related condition(s)?
- ❑ Yes (continue on to question #2)
- ❑ No (continue on to question #3)

2) If yes, do you expect that treatment will be completed within the allocated 30 sessions for adults/ 40 sessions for children?
- ❑ Yes (please continue on to question #4)
- ❑ No (please continue on to question #3)

3) What complicating or confounding issues are hindering recovery?

Submit this document to:
Crime Victims' Compensation Program
Department of Labor & Industries
Post Office Box 44520
Olympia, Washington 98504-4520

CVCP TREATMENT REPORT: FORM IV

Please use this form if you are seeking authorization for treatment beyond the previously authorized 30 sessions for adults/40 sessions for children. Please note that payment of a claim is also dependent upon processing and approval of the CVCP application for benefits.

BILL PROCEDURE CODE 0125C FOR THIS REPORT.

Victim's Name		CVCP Claim Number
Client's Name (if different then the victim's)		Date treatment began
Clinician's Name	Clinician's Provider Number (if known)	Number of sessions to date
Clinician's Address		Clinician's Phone Number ( )
City		State Zip+4

Please review the CVCP guideline on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) What were the diagnoses at treatment onset?

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V/ Current GAF:
Highest GAF past year:

Turn page to continue

2) What are the current diagnoses ***(if different from those listed above)***?

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V/ Current GAF:
Highest GAF past year:

3) Request for extended sessions ***(Complete both sections in either A, B or C, whichever is applicable)***

A. Substantial progress toward treatment goals has been made. Explain:

Please explain the proposed plan for treatment and the number of sessions you are requesting. Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant others.

Turn page to continue

B. Partial progress toward treatment goals has been made.
Explain:

Please explain the proposed plan for treatment and the number of sessions you are requesting. Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant others.

Turn page to continue

C. Little/no progress toward treatment goals has been made.
Explain:

Please explain the proposed plan for treatment and the number of sessions you are requesting. Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant others.

Submit this document to:
Crime Victims' Compensation Program
Department of Labor & Industries
Post Office Box 44520
Olympia, Washington 98504-4520

CVCP TREATMENT REPORT: FORM V

Please use this form if you are seeking authorization for treatments beyond the previously authorized 50 sessions for adults/60 sessions for children. Payment for treatment provided will also be dependent upon the processing and approval of the CVCP application for benefits.

BILL PROCEDURE CODE 0126C FOR THIS REPORT.

Victim's Name		CVCP Claim Number
Client's Name (if different then the victim's)		Date treatment began
Clinician's Name	Clinician's Provider Number (if known)	Number of sessions to date
Clinician's Address		Clinician's Phone Number ( )
City		State Zip+4

Please review the CVCP guideline on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) What were the diagnoses at treatment onset?

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V/ Current GAF:
Highest GAF past year:

Turn page to continue

2) What are the current diagnoses ***(if different from those listed above)***?

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V/ Current GAF:

Highest GAF past year:

3) Request for extended sessions ***(Complete both sections in either A, B or C, whichever is applicable)***

A. Substantial progress toward treatment goals have been made.
Explain:

Please explain the proposed plan for treatment and the number of sessions you are requesting. Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant others.

Turn page to continue

B. Partial progress toward treatment goals has been made.
Explain:

Please explain the proposed plan for treatment and the number of sessions you are requesting. Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant others.

Turn page to continue

C. Little/no progress toward treatment goals has been made.
Explain:

Please explain the proposed plan for treatment and the number of sessions you are requesting. Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant others.

Submit this document to:
Crime Victims' Compensation Program
Department of Labor & Industries
Post Office Box 44520
Olympia, Washington 98504-4520

CVCP TERMINATION REPORT: FORM VI

Please use this form if you are no longer conducting treatment.

BILL PROCEDURE CODE 0127C FOR THIS REPORT.

Victim's Name		CVCP Claim Number
Client's Name (if different then the victim's)		Date treatment began
Clinician's Name	Clinician's Provider Number (if known)	Number of sessions to date
Clinician's Address		Clinician's Phone Number ( )
City		State Zip+4

Please review the CVCP guideline on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) Date of last session: _____

2) Diagnosis at the time of client stopped treatment:

Turn page to continue

3) Reason for termination ***(check all that apply)***:

_ Current goals achieved

_ Client choice to terminate treatment

_ Therapist choice to terminate treatment

_ Parent/guardian choice to terminate treatment

_ Client relocated

_ Client unavailable

_ Client referred to other services

_ Other

4) At this point in time, do you believe there is any permanent loss in functioning as a result of the crime injury? If yes, please describe symptoms based on diagnostic criteria for a DSM diagnosis.

A. TREATMENT ISSUES: OVERVIEW

In the following section on treatment issues, the mental health conditions most commonly experienced by adult and child victims of crime will be discussed. Additionally, these guidelines will address the use of interpreters and advocacy services; providing culturally competent and relevant services to crime victims; and treating clients with disabilities.

These guidelines are based on empirical findings and expert clinical consensus. They have been developed to reflect current knowledge and generally accepted practice concerning the conditions that most commonly affect victims in the aftermath of a crime. The primary objective of the following treatment guidelines is to help clinicians formulate accurate diagnoses, choose and plan assessment strategies and implement appropriate, effective treatment plans for crime victims.

Post-Traumatic Stress Disorder (PTSD) has been identified as the primary trauma-specific diagnosis along with its newly identified acute variation: Acute Stress Disorder. Depressive symptoms, although they are not necessarily trauma-specific, are the other most common symptoms suffered by crime victims. Recommendations and guidelines regarding the identification, diagnosis, assessment and treatment of PTSD and Depression will be presented in Sections B and C, respectively.

Each crime victim's experience and response to trauma is unique and influenced by a myriad of complex variables, e.g., biological and emotional disposition, preexisting conditions, intensity and severity of trauma, exposure to multiple traumas, co-morbid disorders, and the victim's own support system. For this reason, the clinician must carefully consider multiple Axis I disorders and the presence of Axis II and III disorders in order to adjust the assessment and treatment plan accordingly. Section D addresses some of the issues confronted by clinicians managing complex cases and CVCP guidelines regarding treatment of co-morbid conditions. Issues related to the diagnosis, assessment and treatment of the following co-morbid conditions are briefly described in the following sub-sections:

1. **Introduction**
2. **Anger**
3. **Anxiety**
4. **Substance Abuse**
5. **Somatoform Disorders**

These guidelines are not expected to apply to all crime victims or specific situations, nor are they intended to establish a legal standard of care or a rigid standard of practice to which professionals are expected to adhere. Brief summaries of treatment interventions are presented. Please refer to the full treatment manuals listed for detailed descriptions of specific interventions. The adaptation of these guidelines to particular clients requires clinicians to have skill, training, knowledge and experience. Therefore, it is an expectation that practitioners treat within their scope of knowledge and expertise—an expectation which not only applies to crime victims but other clinical populations as well. As experience and scientific knowledge expand, further revision of these guidelines is expected.

All clinicians are expected to keep informed of new developments in the field. These guidelines are not intended to substitute for specialized training and ongoing supervision. The resource lists and bibliographies are only suggestions. They are not exhaustive lists, and the CVCP does not claim responsibility for the services provided.

B. POST-TRAUMATIC STRESS DISORDER

1. INTRODUCTION

Post-Traumatic Stress Disorder (PTSD) is a persistent and sometimes crippling condition precipitated by psychologically overwhelming experience. It develops in a significant proportion of individuals exposed to trauma and, untreated, can continue for years. Its symptoms can affect every life domain- physiological, psychological, occupational and social.

Posttrauma stress reactions have been recognized throughout history. They are described in classical Greek literature and in the early literature of scientific medicine, but it was first diagnostically defined in modern times in the 1980 American Psychiatric Association Diagnostic and Statistical Manual. The surge of scientific and clinical interest in the condition over the past two decades has been largely due to awareness of problems identified among returning Vietnam combat veterans and advocacy by the feminist movement on behalf of rape victims. PTSD has now been documented in other groups including abused children, victims of crimes, accidents, and natural disasters.

Not all trauma survivors develop PTSD. About 20% of crime victims, across types of crime, will meet diagnostic criteria. The rates are substantially higher for some crimes. For example, more than half of rape victims are afflicted. However, most crime victims do have some initial PTSD symptoms that subside over time.

DIAGNOSTIC CRITERIA

The diagnosis of PTSD, as described in the *DSM-IV* (APA, 1994), requires the presence of a defining traumatic experience and certain symptoms. A person must A1) have been subjected to an experience that threatened loss of life or identity or serious injury, and A2) have reacted to that event with intense emotion- horror, fear, or helplessness; B) re-experience the event in dreams, flashbacks, vivid intrusive thoughts, or emotional and physiological reactions to reminders of the event; C) show three or more avoidant and/or numbing features associated with the event; D) exhibit symptoms of arousal. ***(See Table 1 on page 46 for a listing of symptoms.)*** Additional diagnostic requirements include that at least a month must have elapsed since the index event and that the person have some functional disability- inability to function normally at work, in their families, or within their social networks.

The current *DSM-IV* criteria rely heavily on items that require verbal descriptions of internal experiences and states. There is growing consensus that more developmentally sensitive criteria are needed for children due to their limited ability to express their subjective experiences. The current modifications in the *DSM-IV* symptom criteria for children are presented in bolded text in Table 1.

Some experts have proposed a variant known as Complex PTSD. In this condition individuals may have more pervasive disturbances, including identity problems, difficulties in affect regulation. Complex PTSD is not an officially sanctioned diagnosis at this time.

TABLE 1: POST-TRAUMATIC STRESS DISORDER *DSM IV* DIAGNOSTIC CRITERIA				
Criterion A: Trauma (Both)	**Criterion B:** Re-experiencing Symptoms (1+)	**Criterion C:** Numbing and Avoidant Symptoms (3+)	**Criterion D:** Arousal Symptoms (2+)	**Criterion E&F:** Additional Diagnostic Requirements
1. Traumatic event and 2. Intense response; may be expressed by **disorganized or agitated behavior**	1. Intrusive thoughts of trauma or **repetitive posttraumatic play** 2. Recurrent nightmares (**includes those w/o recognizable content**) 3. Flashbacks or **trauma-specific reenactment** 4. Distress at reminders of the trauma 5. Physiological reaction to reminders	1. Avoids thoughts/feelings 2. Avoids activities/people 3. Failure of recall regarding the trauma 4. Loss of interest significant activities 5. Detachment from others 6. Restricted affect 7. Lost sense of the future	1. Insomnia 2. Irritability 3. Difficulty concentrating 4. Hypervigilence 5. Exaggerated startle response	Duration of Sxs: > one month and Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Key: **Bolded text** = modifications in diagnostic criteria for children

BIOLOGIC CHARACTERISTICS

There is increasing evidence that PTSD is associated with biological alterations or abnormalities. Individuals with PTSD have an atypical stress response. Instead of producing increases in cortisol, a stress related hormone, the usual hypothalamic-pituitary axis mechanisms are disrupted and result in lower than expected levels of the hormone. It is possible to induce PTSD symptoms in diagnosed individuals with injection of relatively benign chemical stimuli. Decreased total brain volume or volume of specific brain structures has been documented in some adults and children with PTSD. The biologic correlates have not yet been fully explored, nor are the implications for intervention established.

POPULATIONS AT RISK

According to general population surveys conducted over the past five years, PTSD is among the most common psychiatric conditions in American society. Younger adults and adolescents seem somewhat more susceptible than older adults. Less is known about the very young, who respond to trauma in less typical ways, but post-traumatic syndromes are believed to occur and to exert profound influences on development and later emotional health.

One representative national sample of women revealed a life-time prevalence of PTSD of 12.3% and rate of current PTSD of 4.6 % (Resnick et al.,1993). The authors estimated that 11.8 million adult women in the U.S. would have experienced PTSD at some time during their lives, and 4.4 currently have PTSD. This study found a significantly higher rate of PTSD among crime versus non-crime victims (25.8% vs. 9.4%). Another general population study (Kessler, et al, 1995) reported a lifetime prevalence of 7.8% (5% of men; 10.4% of women).

There is a single nationally representative survey of adolescents that assessed for PTSD diagnosis (Kilpatrick & Saunders 1997). This study found that 8.1% of the adolescents surveyed met DSM-IV criteria for PTSD during their lifetime and 4.9% currently met criteria. They estimated that 1.8 million adolescents in the U.S. meet the *DSM-IV* criteria at some point during their lifetime and 1.1 million currently suffer from PTSD. The survey also showed that the rates of lifetime and current PTSD increase significantly with age; by age 17, the rates of lifetime and current PTSD increased to 13.1% and 8.4%, respectively.

People vary in susceptibility to PTSD. Younger adults and adolescents seem somewhat more susceptible than older adults. Less is known about the very young, who respond to trauma in less typical ways, but post-traumatic syndromes are believed to occur and to exert profound influences on development and later emotional health. Genetic factors may play a significant role in susceptibility. Women develop PTSD at about twice the rate as men, even for the same crimes. Individuals with a prior trauma history or multiple traumas are at increased risk. A premorbid psychiatric history also increases the likelihood of developing the disorder. It may be that people who have fewer supports and limited inter-personal coping skills are also more likely to develop PTSD. Studies of concentration camp survivors and prisoners of war, however, suggest that given sufficient trauma intensity and duration most of those who are exposed develop PTSD.

The nature of the event and the person's response affects development of PTSD. A positive relationship has been found between trauma intensity and the likelihood of PTSD. People who have been injured or perceived the event as life threatening are more likely to develop PTSD than those with less severe trauma. Human caused traumatic events such as interpersonal violence have a more powerful impact than accidents and natural disasters. Among crime victims, individuals who suffer more brutal trauma, torture, rape, aggravated assault, have higher frequencies of PTSD. Dissociation during the trauma, peritraumatic dissociation, is associated with risk for PTSD.

As previously mentioned, most crime victims experience PTSD symptoms although they do not develop the disorder. Reexperiencing and arousal symptoms are almost universal in the immediate aftermath. Similar relationships are found between the nature and severity of trauma and PTSD symptoms in adults and adolescents (Boney-McCoy & Finkelhor, 1995; Norris & Kaniasty, 1994).

Cognitive distortions and faulty attributions are commonly associated with PTSD and increase for the development for the disorder. Maladaptive cognitions may be specifically related to the trauma per se. Guilt and shame about aspects of the experience or the fact of being victimized are the most common. Other cognitive impacts reflect alterations in basic assumptions about self, others and the world.

CLINICAL COURSE

Once established PTSD tends to persist. About half of those who develop PTSD spontaneously recover over the two years following the event. After that time symptoms may wax and wane in intensity or different clusters may be more prominent at a particular time, but they usually do not dissipate entirely. Anniversaries and life crises may precipitate setbacks.

CO-MORBIDITY—ADULTS

Individuals with PTSD often suffer from other psychiatric conditions; nearly 80% of women and 90% of men with lifetime history of PTSD develop at least one other disorder (Kessler et al., 1995). Depression accompanies PTSD almost half of the time (Davidson & Foa, 1993). Substance abuse develops frequently, particularly among men, whereas women are more prone to psychologically determined physical complaints. Anxiety disorders (i.e. generalized affective disorder, panic disorder, simple phobia, social phobia, agoraphobia) are common among both sexes. Co-morbidity with PTSD would be expected for some of these disorders due to the overlap in symptom criteria; for example, criteria C and D PTSD symptoms (e.g., diminished interest, restricted range of affect, sleep disturbances, difficulty concentrating) overlap with several of the hallmark symptoms of depression. Similarly, Criterion D PTSD symptoms (e.g. irritability, hypervigilance, exaggerated startle) overlap with symptoms that characterize generalized anxiety disorder and criterion B5 (physiological reactivity) could overlap with panic disorder, simple phobia, and/or social phobia ***(see Table 1 on page 46)***.

CO-MORBIDITY—CHILDREN

Children with PTSD also have fairly high rates of psychiatric co-morbidity (AACAP, 1998). Depression and other anxiety disorders (e.g. agoraphobia, separation anxiety, and generalized anxiety disorder) are quite common in children who have been traumatized. Other children may respond to trauma by displaying externalizing symptoms-or behavioral problems. Disruptive behavior disorders, like Conduct Disorder and Oppositional-Defiant Disorder, are not uncommon among children with PTSD, and are most often associated with physical abuse, exposure to violence, or coercive family dynamics. Young children often present anxiety-related responses manifested by hyperactivity, distractibility, and impulsivity which are hallmarks of Attention- Deficit Disorder (ADHD). However, some authors have suggested that ADHD in traumatized children may actually be misdiagnosed PTSD.

2. ACUTE STRESS DISORDER

OVERVIEW

Many victims of crime suffer from a variety of short-term posttraumatic stress and dissociative symptoms during or immediately after the trauma. Although these reactions do not necessarily lead to PTSD, they can cause significant emotional and psychological distress as well as functional impairment. The diagnosis of Acute Stress Disorder (ASD) was recently incorporated into the *DSM-IV* in order to recognize and classify the psychological reactions and sequelae that occur within one month after an acute stressor (Briere, 1997).

DIAGNOSTIC CRITERIA

The defining features of ASD are the development of dissociative and posttraumatic stress symptoms that occur within one month of the traumatic event (APA, 1994). The diagnostic criteria of ASD similar to PTSD regarding the stressors involved and the symptoms experienced, except that only one symptom each of the reexperiencing, avoidant, and arousal clusters are required for an ASD diagnosis ***(See Table 2 on page 49.)*** The individual must have **at least three** of the following dissociative symptoms during or after experiencing the traumatic event: (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness, (2) a reduction in awareness of his or her surroundings (e.g., "being in a daze"), (3) derealization, (4) depersonalization and/or (5) dissociative amnesia (i.e. inability to recall an important aspect of the trauma) (APA, 1994).

TABLE 2: ACUTE STRESS DISORDER DSM IV DIAGNOSTIC CRITERIA				
Trauma (Both)	Dissociative Sx (3+)	Re-experiencing Sx (at least 1)	Anxiety or Arousal Symptoms (at least 1)	Additional Diagnostic Requirements
1. Traumatic event and 2. Intense response	1. Subjective sense of numbing, detachment, or absence of emotional responsiveness 2. A reduction in awareness of his or her surroundings 3. Derealization, 4. Depersonalization and/or 5. Dissociative amnesia.	1. Intrusive thoughts of trauma 2. Nightmares 3. Flashbacks 4. Distress at reminders of the trauma 5. Physiological reaction to reminders of the trauma Avoidant Symptoms (at least 1) Avoids trauma reminders: 1. Thoughts, feelings 2. Conversations, activities 3. People, places	1. Insomnia 2. Irritability 3. Difficulty concentrating 4. Hypervigilence 5. Exaggerated startle response 6. Motor restlessness	**Duration of Sxs:** 2 days to 4 weeks **And** Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. **And** The disturbance is not due to the direct physiological effects from substance abuse of a drug or use of a medication.

DURATION

This disturbance lasts for a minimum of two days and does not persist beyond four weeks; when symptoms persist beyond 1 month, a diagnosis of PTSD may be appropriate if the full criteria are met. ASD symptoms and reactions must also **occur within four weeks of the traumatic event**, whereas PTSD diagnosis requires that **at least one month** has elapsed since the traumatic index event.

3. ASSESSMENT AND MANAGEMENT OF PTSD IN ADULTS

DIAGNOSTIC CRITERIA

Please read the Diagnostic Criteria section on page 45.

ASSESSMENT

There are a number of excellent assessment guides that have been recently published to help mental health professionals through this process (See Briere, 1997; Carlson, 1997; Wilson & Keane, 1996; Stamm, 1996; van der Kolk et al., 1996). The following recommendations for PTSD assessment are based on this current literature.

1. Planning and Preparing for Assessments

It is important to provide a neutral or positive, and safe setting for the evaluation. Clinicians should be aware of the potential re-traumatizing effects of assessment interviews and the use of probing techniques. The assessment setting or clinician characteristics may resemble those of the offender or the traumatic scene and reactivate posttraumatic stress. Recalling and describing the traumatic event during the assessment may also trigger intense feelings of distress and a desire to escape or avoid the situation. Clinicians should anticipate and be prepared to respond to distress reactions. For example, a clinician may choose **not** to administer a particular psychological test or delay having the victim provide a detailed description of the traumatic event until they are more stable.

Clinicians must strive to maintain victim state of well being and avoid potential harm. It follows that the pacing, tone, and preparation for the interview should be carefully considered and adjusted as necessary. The developmental and comprehension level of the client must also be taken into account. Alerting victims beforehand that they may experience assessment-related distress, as well as providing assurance and grounding afterwards may be helpful (e.g. reminding them that they are safe; explaining that their reactions are reasonable due to circumstances) (Briere, 1997).

2. Objectives of Assessment

The primary task in assessing PTSD is to firmly establish the presence of specific symptoms of the disorder (van der Kolk et al., 1996). It should **not** be assumed that clients suffer from PTSD solely because they have been exposed to a high-magnitude stressor; it is possible they suffer from another condition that may or may not be associated with exposure to trauma.

Clinicians will need to query victims regarding the presence of **all** symptom criteria occurring within the specified time range. To do this, enough **accurate** information about traumatic experience will need to be gathered by asking specific questions. Obtaining a precise factual account of the traumatic event may not be as important as learning about **perceptions** of the experience. For example, perceived life threat has as much influence on the development of PTSD as objective factors such as injury of threat of violence. Victim reports of symptoms and experiences are the major source of clinically relevant information. Sometimes however, victims underreport or overreport their symptoms because of high levels of emotional distress, faulty thinking patterns, avoidant coping mechanisms or because they wish to justify or explain their problems. In an attempt to maximize the accuracy of victims' reports, **systematic** assessment methods are a critical part of this process.

Another assessment goal involves determining, when possible, whether victims' current state and symptoms are a result of the index traumatic event. Careful questioning about the content, initial onset, and external cues associated with symptoms can help improve understanding of complex relationships between the symptoms and the stressor. Furthermore, because research has indicated that those who have experienced a significant stressor are more likely to be exposed to two or more stressors over the life span, it is important to explore this possibility in the assessment. Since posttraumatic stress is often accompanied by other significant coexisting disorders (e.g. depression, anxiety disorders, alcohol and drug abuse), other diagnostic possibilities should be considered and ruled out.

3. Assessment Strategies

It is considered the ideal by experts in the field that assessment involve a "semi-structured clinical interview assessing lifetime exposure to potentially traumatic events, PTSD, and other disorders, as well as self-report measures, psychophysiological assessment, and collateral assessment" (Newman et al., 1996, p. 243). However, this level of comprehensiveness is not necessary or feasible in every case. At minimum a standard clinical assessment with specific attention to the impact of the traumatic event should occur prior to the onset of treatment.

Numerous standardized measures of traumatic experiences exist. They range from self-report measures, inventories, and questionnaires to structured interviews. Carlson (1997) provides a comprehensive list and description of recommended assessment measures. See Table 3 on page 52 for a sample of profiled instruments.

Preliminary information about trauma history, psychiatric status, and level of functioning guide clinical decision-making about the comprehensiveness of the assessment process. For example, if a victim has experienced a recent assault and the clinician is aware of a history of other traumas and preexisting conditions, a more detailed structured interview assessing a wide range of traumatic events and psychological symptoms and conditions is indicated. On the other hand, an otherwise well functioning victim who appears to be suffering some PTSD symptoms but does **not** report other history will not require an extensive battery or detailed assessment for all possible diagnoses.

TABLE 3: SAMPLE OF PROFILED INSTRUMENTS

Name & Type of Instrument	Recommended Uses	*Target Pop* & Time Frame Assessed	*DSM* Version Used	Descriptive Info: The Potentially Traumatic Events Assessed by this Instrument	Special Features/ Comments	Question Format	Response Type: *# of Items*: Time to administer: *depends on # of traumatic experiences	Psychometric Info: Validation pop (VP): Reliability (R): Validity (V):	How to Obtain a Scale: Contact
Self-Report Inventories of Traumatic Experiences									
Trauma Assessment for Adults (TAA)-Self-Report (H. Resnick, C. Best, D. Kilpatrick, J. Freedy, & S. Falsetti)	For brief screening for trauma history	*Adults* Lifetime	Assesses DSM-IV Criterion A-1, BUT NOT A-2 element.	Combat, accidents, disasters, serious illnesses, sexual assault and physical assault (child & adult), assaults w/ weapons, witnessing death or serious injury, friend/family member killed/murdered.	Includes detailed assessment of child sexual assault & probes to assess threat, injury, and penetration to evaluate severity of incident.	"At anytime in your life has anyone (including family members or friends) ever attacked you with a gun, knife, or some other weapon, and regardless of whether you ever reported it?"	yes/no *17 items* 10 -15 min*	VP: None R: None V: None	Heidi Resnick, PhD, Natl Crime Victims Rx and Tx Center, Dept. of Psychiatry and Behavioral Sciences, 171 Ashley Avenue, Charleston, SC 29425 (843-722-0082)
Trauma History Questionnaire (B. Green)	For brief screening for trauma history	*Adults* Lifetime	Assesses DSM-IV Criterion A-1 element for *some* events, not all & NOT Criterion A-2	Mugging, being robbed, home broken into, accidents, disasters, "man-made" disasters, exposure to environ. hazards, other situations with threat of death/ serious injury, witnessing death/serious injury, sexual assault & physical assault (w/ & w/o weapon) etc.	Includes detailed items inquiring about specific potentially traumatic crime-related events.	"Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick-up or mugging?"	yes/no, # of times, age. *24 items* 5 -15 min*	VP: Psychiatric outpatients, college students, & women with breast cancer R : high test-retest reliability V: Some norms collected	Bonnie L. Green, PhD, Department of Psychiatry, Georgetown University, 611 Kober Cogen Hall, Washington, DC 20007
Interviews for Traumatic Experiences									
Childhood Trauma Interview (L. Fink)	For collecting detailed info about childhood interpersonal traumatic experiences	*Adolescent* Childhood to 18 yrs	Does NOT assess DSM-IV Criterion A-1 element of threat of death & threat of or actual injury of Criterion A-2 element	Childhood separation and loss, Physical neglect, emotional abuse/assault, physical assault,witnessing violence, and sexual assault.	Unique in providing a means of quantifying the frequency, severity,& duration of a wide range of interpersonal traumatic events.	"Did either of your parents, or anyone else who took care of you die while you were growing up?"	Open-& close-ended questions *49 items* 20-40min*	VP: Drug-or alcohol-dependent patients R: Interrater high (Fink et al., 1995) V: Construct Validity	Laura Fink, PhD, c/o Josephine Dodge, Bronx VA Medical Center, Psychiatry Service 116A, 130 West Kingsbridge Road,Bronx, NY 10468

Name & Type of Instrument	Recommended Uses	*Target Pop* & Time Frame Assessed	*DSM* Version Used	Descriptive Info: The Potentially Traumatic Events Assessed by this Instrument	Special Features/ Comments	Question Format	Response Type: # *of Items*: Time to administer: *depends on # of traumatic experiences	Psychometric Info: Validation pop (VP): Reliability (R): Validity (V):	How to Obtain a Scale: Contact
Evaluation of Lifetime Stressors (ELS) (K. Krinsley F. Weathers, M. Vielhauer, E. Newman, E. Walker, D. Kaloupek, L. Young, & R. Kimerling)	For collecting detailed info about potentially traumatic experiences	*Adults & Adolescent* Lifetime	Assesses DSM-IV Criterion A-1 & A-2	28 different events: disasters,illnesses, accidents, street/criminal violence,combat,physical assault & sexual assault as well as a range of experiences/sxs in childhood & adulthood associated w/ trauma	Unique format;self-report questionnaire is used in conjunction with a follow-up semistructured interview. Endorsed items are queried about in detail; Design emphasizes clinical sensitivity.	"Have you ever witnessed or experienced a robbery, mugging, or violent attack?" Further queries re: specifics and details.	"yes, this happened to me, Im not sure if..," "No, but this happened to someone I knew" or "No..." *56 items* 10-20 min for questionnaire, 1-3+ hrs for interview	VP: Male Veterans, female sexual assault survivors R: test-retest reliability V: None	Karen Krinsley,PhD, National Center for PTSD (116B-2), Boston VA Medical Center, 150 South Huntington Avenue, Boston,MA 02130
National Women's Study Event History (D. Kilpatrick, H. Resnick, B. Saunders, & C. Best)	For collecting detailed info. about potentially traumatic experiences	*Adults* Lifetime	Assesses DSM-IV Criterion A-1 but NOT A-2	Serious accidents, natural disasters, witnessing death/injury, friend or family member killed,completed rape, molestation, attemped sexual assault & physical assault	Detailed assessment of fires,most recent & worst rape experiences, single molestation & attempted sexual assault and physical assault;carefully worded.	"During your lifetime, have any of the following types of things ever happened to you? A serious accident at work, in a car, or somewhere else?" Further probes re: details.	Yes/No; probes include closed- and open- ended questions *17 items* 15-30 min*	VP:Frequency of exposure to trauma has been gathered for a racially and demographically representative natl' sample of women between 18-34 yrs. R: None V: Construct validity	Dean Kilpatrick,Phd, Natl Crime Victims Rx and Tx Center, Dept.of Psychiatry and Behavioral Sciences, 171 Ashely Ave, Charleston, SC 29425-0742 (843-722-0082)
Trauma Assessment for Adults (TAA)-Self-Report (H. Resnick, C. Best, D. Kilpatrick, J. Freedy, & S. Falsetti)	For brief screening for trauma history For Adults	*Adults* Lifetime	Assesses DSM-IV Criterion A-1 but NOT A-2.	Combat, accidents,disasters,serious illnesses,SA & PA (C& A),assaults w/ weapons, witnessing death or serious injury, friend/family member killed/murdered.	Includes detailed assessment of CSA, including probes to assess threat,injury, & penetration to allow evaluation of severity of incidents.	"During your life,have any of the following types of things ever happened to you? Military Combat experience or military service in a war zone?"	Yes/No & other aspects of events *13 items* 10-15 min*	VP: Adult mental health center clients R: None V: Construct validity	Heidi Resnick, PhD, National Crime Victims Rx and Txt Center, Dept. of Psychiatry and Behavioral Sciences, same as above
Traumatic Stress Schedule (F. Norris)	For brief screening for trauma history	*Adults* Published version specifies past year, but author suggests it may be used to assess any specified time period.	Assesses DSM-IV Criterion A-1 but NOT A-2.	Combat, robbery/mugging, sexual assault and physical assault ,traffic accidents, sudden death of loved one, disasters, exposure to environmental hazards, terrifying/shocking experiences, & major life changes.	Flexible interview format w/ 9 screening questions & very detailed probes for each endorsed question.	"In the past year,did anyone take something from you by force or threat of force, such as in a robbery, mugging, or hold-up?" Probe about details	Yes/No; probes include closed- and open- ended questions. *10 screening items* w/ 12 probes for each 5-30 min*	VP: Freq of exposure to trauma was gathered for 6 southeastern U.S. cities R: test-retest across English & Spanish versions V: construct validity supported	Fran Norris, PhD, Dept of Psychology, Georgia State University, University Plaza, Atlanta, GA 30303

Name & Type of Instrument	Recommended Uses	*Target Pop* & Time Frame Assessed	*DSM* Version Used	Descriptive Info: The Potentially Traumatic Events Assessed by this Instrument	Special Features/ Comments	Question Format	Response Type: # *of Items*: Time to administer: *depends on # of traumatic experiences	Psychometric Info: Validation pop (VP): Reliability (R): Validity (V):	How to Obtain a Scale: Contact
Self-Report Measures of Responses to Trauma									
Davidson Trauma Scale (DTS) (J. Davidson)	To measure PTSD sxs related to identified trauma	*Adults* Past Week	Assesses DSM-III-R & DSM-IV sx criteria (B,C,D) for PTSD	DSM-III-R/DSM-IV sxs for PTSD	Brief & easy to administer,yields scores for both frequency & severity of PTSD sxs.	"Have you had painful images,memories, or thoughts about the event?"	For each item,client rates frequency & severity (0-4) 0 ="Not at all" to 4 ="Every day" *17 items* 10-15 min	VP: Rape victims,war veterans,hurricane victims,& survivors of misc. traumas R: Internal consistentcy & test-retest reliability. V: construct and convergent validity	Mental Health Systems, Inc.,908 Niagara Falls Boulevard, North Tonawanda,NY 14120-2060; 1-800-456-3003
Dissociative Experiences Scale (DES) (E. Carlson & F. Putnam)	For measuring dissociation sxs	*Adults* None specified	Assesses domains of dissociative amnesia, gaps in awareness, derealization, depersonal-ization, absorption, & imaginative involvement.	Contains items corresponding to sxs of dissociative disorders & PTSD but does NOT specifically assess DSM criteria for any disorder.	Brief,inquires about the frequency of a wide range of pathological and normative dissociative experiences; translated into 16 languages.	"Some people have the experience of feeling that other people, objects, and the world around them are not real. Circle a # that to show what % of the time this happens to you."	For each item,client rates frequency by circling a number on 11-pt scale ranging from 0=never to 100=always (multiples of 10) *28 items* 5-10 min	VP: Used in over 250 published studies/wide range of populations R: Internal consistency, & test-retest reliability V: construct validity & convergent validity	Sidran Foundation, 2328 West Joppa Road, Suit 15, Lutherville, MD 21093; 410-825-8888
Impact of Event Scale-Revided (IES-R) (D. Weiss & C. Marmar)	To screen for or measure PTSD sxs related to a single identified traumatic event.	*Adults* Past 7 days	Assesses 14 of the 17 DSM-III-R/ DSM-IV sxs for PTSD	Assesses 14 of the 17 DSM-II-R & DSM-IV sx criteria (B,C,D) for PTSD	Very brief & easily administered; a revised version of the oldest and most widely used measure of trauma responses.	"Any reminders brought back feelings about it."	Client rates degree of distress assoc. w/ each item (O="Not at all" to 4= "Extremely" *22 items* 5-10 min.	VP: Earthquake survivors,emergency disaster workers, Vietnam combat vets, M/Fsubject to violence, sexual assault/F R: internal & test-retest consistency. V: construct validity	Daniel Weiss, PhD, Deprtment of Psychiatry, Univ. of California-San Francisco, Box F-0984,San Francisco, CA 94143-0984
Modified PTSD sx Scale: Self Report Version (MPSS-SR) (S. Falsetti,P.,Resick, H. Resnick, & D. Kilpatrick)	For measuring PTSD sxs; esp. useful for clients w/ hx of multiple traumatic events or for clients w/ unknown trauma hx.	Adults Past 2 weeks	Assesses DSM-III-R and DSM-IV sx Criteria (B,C,D) for PTSD.	Assesses DSM-III-R/DSM-IV sxs for PTSD.	Does not key sxs to any single traumatic event, it inquires about each sx in general & then asks what event its related to. Yields scores for both frequency & severity of PTSD sxs.	"Have you had repeated upsetting thoughts that happened even when you didn't want them to?" "About which event(s)?	Client rates freq (O="Not at all"; 3="5 or more times/week" severity rated (A-D) A=Not at all distress-ing; D= extremely distressing *17 items* 10-15 min	VP: Psychiatric patients exposed to various traumatic experiences & a community sample R: internal consistency V: construct validity	Sherry Falsetti, Phd, Medical University of South Carolina , Crime Victims Rx & Tx Center, 171 Ashley Avenue, Charleston,SC 29425-0742.

Name & Type of Instrument	Recommended Uses	*Target Pop* & Time Frame Assessed	*DSM* Version Used	Descriptive Info: The Potentially Traumatic Events Assessed by this Instrument	Special Features/ Comments	Question Format	Response Type: # *of Items*: Time to administer: ***depends on # of traumatic experiences**	Psychometric Info: Validation pop (VP): Reliability (R): Validity (V):	How to Obtain a Scale: Contact
Penn Inventory for Posttraumatic Stress Disorder (M. Hammarberg)	For screening for PTSD Can be used with clients with multiple traumatic experiences.	*Adults* Past Week	Does NOT directly correspond to DSM sx criteria for PTSD.	Items are generally based on DSM-III-R/DSM-IV sxs for PTSD but do ot assess all of the DSM sxs. Some sxs are assessed by >1 item (eg intrusive thoughts) & other non-DSM sxs (eg self-knowledge) are assessed.	Unique response format: similar to the Beck Depression Inventory.	0="I know someone nearby who really understands me"; 1= "I'm not concerned whether anyone nearby really understands me"; 2= "I'm worried because no one nearby really understands me" 3= "I'm very worried…" etc.	For each item, clients circle a # next to the 1 statement of 4 that best describes their feelings. *26 items* 5-15 min	VP: Combat veterans,Vietnam-era veterans,oil-rig disaster survivors. R: internal consistency and test-retest reliability V: construct & convergent validity	Melvyn Hammarberg, PhD, Dept of Anthropology, University of Pennsylvania,325 University Museum, 33rd and Spruce Street, Philadelphia, PA 19104-6398
Posttraumatic Stress Diagnostic Scale (PDS) (E. Foa)	To measure severity of PTSD sxs related to a single identified traumatic event. Also can be used to make prelim. DSM-IV PTSD diagnosis	*Adults* Past Month: time frame can be adjusted for different uses	Assesses all DSM-IV criteria for PTSD (A,B,C,D,E,& F)	Assesses all DSM-IV sxs for PTSD	Unique b/c it assess all of the DSM-IV criteria. Inquires about severity, experience of Criterion A traumatic events, duration of sxs, & effects of sxs on daily functioning.	"Having upsetting thoughts or images about the traumatic event that came into your head when you didn't want them to."	Client gives a severity rating that reflects frequency (from 0="Not at all or only 1 time" to 3="5 or more times/week/almost always" *49 items* 10-15 min	VP: Accident/ fire, natural disaster, non SA,SA,combat, life-threatening illness. R: internal consistency & test-retest reliability V: construct & convergent validity	National Computer Systems (NCS), 5605 Green Circle Drive, Minnetonka, MN 55343; 800-627-7271 (ext. 5151).
Revised Civilian Mississippi Scale for PTSD (R-CMS) (F. Norris & J. Perilla)	To measure PTSD sxs related to a single identified traumatic event	*Adults* "Since the event."	Contains items that correspond to DSM-III-R/ DSM-IV sx criteria (B,C,D) for PTSD.	Assesses DSM-III-R/DSM-IV sx criteria (B,C,D) for PTSD & other sxs assoc. w/PTSD (guilt)	Uses very simple response format easily understood by clients, available/valid in Spanish.	"If something happens that reminds me of the event, I become very distressed and upset."	Client rates on a scale from 1="Not at all true" to 5="Extremely true" Items reflect degree, frequency, & severity of sxs *30 items* 5-10min	VP: Two bilingual community samples & hurricane victims R: internal consistency and retest-test reliability V: construct validity	Fran Norris,PhD, Department of Psychology,Georgia State University, University Plaza, Atlanta,GA 30303
Screen for Posttraumatic Stress sxs (SPTSS) (E.Carlson)	For screening for PTSD sxs. Useful for clients with histories of multiple traumatic experiences or whose trauma history is unknown.	*Adults* Past 2 weeks	Asesses DSM-III-R & DSM-IV sx criteria (B,C,D) for PTSD.	Asesses DSM-III-R and DSM-IV sxs for PTSD	Very brief & does not key sxs to any single traumatic event. First person item wording used-easily understood by clients.	"I get very upset when something reminds me of something bad that happened to me."	For each item, client rates frequency: (O="Not at all" to 10= "Always.") *17 items* 5-10min	VP: Psychiatric inpatients (some w/ exposure to traumatic experiences) R: internal consistency and good consistency over time V: construct & concurrent validity	Eve Carlson,PhD, Clinical Psychology Associates,611 East Walworth Ave., Delavan,WI 53115

Adapted from: Carlson, E.B. (1997). Trauma Assessments: A clinician's guide. New York: Guilford Press

PSYCHOSOCIAL TREATMENT STRATEGIES

Comprehensive reviews of psychosocial interventions (van der Kolk et al., 1996; Meichenbaum, 1994) document that virtually every form of treatment has been used with individuals who have PTSD. Of the various approaches, four strategies have been distinguished by both empirical evaluation and the development of treatment manuals that enhance standardized training of procedures to clinicians. The following approaches can be recommended as current best practices because of their efficacy, goal-focus and brief nature. Currently, only the cognitive-behavioral approaches have been investigated sufficiently to make empirically based recommendations. As Edna Foa notes "nonbehavioral treatments have not been the subject of well-controlled studies to the extent that cognitive-behavioral treatments have. However, this is not to say that they cannot prove effective as well (Foa & Rothbaum, 1998, p. 67). Examples of other forms of interventions used to treat individuals with PTSD include psychodynamic/psychoanalytic therapies, inpatient milieu, and family and couple therapy. The literature regarding these interventions is emerging.

According to the Task Force on Promotion and Dissemination of Psychological Procedures (1995), the four strategies that meet criteria for either "probably efficacious" or "well-established" are briefly described as follows:

1. Prolonged Exposure (PE)

Prolonged Exposure is a standard technique that has been used with various anxiety disorders and has now been adapted for PTSD in rape victims (Foa & Rothbaum, 1998). PE involves repeated imaginal re-living of the traumatic experience. Then it is followed up with subsequent real life exposure to situations that are unpleasant reminders and cause fear. The theory posits that repeated pairing of the emotional memories, with a non-dangerous environment will lead to deconditioning of the emotionally aversive associations to trauma memories. Gradually being reminded or remembering the trauma will lose the intense negative quality. Breathing retraining to assist with relaxation is an initial component of the approach.

Foa and Rothbaum (1998) offer a detailed treatment rationale and manual that specifies the techniques on a session by session basis. The treatment ordinarily is carried out over ninety minute sessions that may occur twice a week.

PE has been proven effective with female victims of rape, with at least 90 days of sobriety if there has been a substance abuse issue. High-risk concerns such as psychosis, homicidal or suicidal tendencies should be addressed. Neither depression nor its management with antidepressants, nor co-morbid personality disorder precludes effective treatment.

Primary Resource:

Foa, E. B., & Rothbaum, B. O. (1998). Treating the trauma of rape: Cognitive-behavioral therapy for PTSD. New York: Guilford.

2. Cognitive Processing Therapy (CPT)

Cognitive Processing Therapy is an approach that focuses primarily on trauma-related attributions and cognitions that are maladaptive. There is exposure to the trauma, but it occurs in a modulated fashion and is accomplished through having victims write descriptions of the trauma that are repeatedly reviewed and read. The description is analyzed to identify blocks and dysfunctional cognitions and cognitive therapy techniques are used to challenge and replace these distortions with more appropriate, accurate and adaptive views. Themes of safety, trust, power, esteem and intimacy are specifically addressed. Coping skills are taught to assist victims in predicting and managing stress responses. CPT has been proven effective with female rape victims.

Resick and Schnicke (1995) provide the theory underlying the approach and a detailed description of the various techniques. The treatment occurs over 12 sessions.

Primary Resource:

Resick, P. A., & Schnicke, M. K. (1993). Cognitive processing therapy for rape victims: A treatment manual. Newbury Park, CA: Sage Publications.

3. Stress Inoculation Training (SIT)

SIT is a CBT approach that has a primary focus on teaching the identification and management of anxiety reactions to stressful situations. Michenbaum (1985) first developed this intervention for use with a wide variety of populations suffering from anxious response including trauma. He has since published a manual (Michenbaum, 1994) that is specifically devoted to PTSD. SIT involves explaining the physical, cognitive and behavioral components of fear and anxiety reactions. Then victims are taught various coping strategies to address disfunctional thoughts and unpleasant feelings that come up with exposure to certain trauma reminders. These include relaxation, shifting attention and self-coaching dialogues. The goal is that victims learn to manage trauma related anxiety with confidence and efficacy.

SIT has been found effective with various stress-related conditions and for female rape victims. Typically this approach consists of 8-14 sessions.

Primary Resources:

Meichenbaum, D. (1985). Stress inoculation training. Boston: Allyn and Bacon.

Meichenbaum, D. (1994). A clinical handbook/practical therapist manual for assessing and treating adults with post-traumatic stress disorder (PTSD). Waterloo, Ontario, Canada: Institute Press.

4. Eye Movement Desensitization and Reprocessing (EMDR)

Shapiro (1995) developed the Eye Movement Desensitization and Reprocessing (EMDR) approach. Like SIT, this approach has been advocated as a treatment for a variety of psychological problems involving intense emotions and intrusive thoughts. It is generally considered a form of imaginal exposure accompanied by cognitive reframing which are standard elements of CBT. Victims are encouraged to imagine a stressful scene and replace dysfunctional cognitions with more adaptive ones while engaging in lateral eye movements. Therapists move fingers back and forth to facilitate this process.

The unique aspect of this treatment is the eye movement component. The currently available research has established that EMDR is as effective as CBT treatments. However, the eye movements have not been found to be necessary and they do not explain symptom reduction.

Initially, it was claimed that EMDR could cure PTSD in one or two sessions. The developer of the method now takes the positions that up to 12 session may be necessary in some cases to achieve full effects.

Primary Resource:

Shapiro, F. (1995). Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures. New York: Guilford.

Discussion

All of the described therapeutic interventions involve some degree of exposure. SIT and other anxiety regulation and management approaches have the greatest amount of empirical support across populations of individuals with anxiety based conditions. A significant component of PE and CPT incorporates aspects of anxiety management. PE (including imaginal and in vivo procedures) has been proven effective as the central ingredient of treatment. Practically, however, exposure to intense imaginal and in vivo stimuli may not always be necessary. The other interventions have as much empirical validity as PE; although they involve exposure, they do so in a more graduated fashion. CPT, for example, uses less intense exposure (writing the trauma account and re-reading it) and emphasizes cognitive processing and restructuring of beliefs.

Pharmacotherapy of Adult PTSD

Though seldom the sole, or even primary treatment for PTSD, pharmacotherapy can alleviate suffering, help restore immediate functioning, and be a supportive adjunct to psychotherapy.

The scientific literature on PTSD pharmacology is relatively sparse. Most studies have been open trials of different medications, only a few randomized trial have been conducted and they have had equivocal results. Treatment guidelines are largely developed on the basis of clinical experience and expert opinion. Antidepressants are the backbone of PTSD treatment; they are particularly useful for their anxiolytic qualities and ability to reduce arousal. The newer selective seratonin reuptake inhibitors and related medications are generally safer, better tolerated, and possibly more effective than older formulations.

A full psychopharmacologic approach can include the use of anticonvulsants and mood stabilizers, major tranquilizers and anti-psychotic medications of which newer drugs are well tolerated, and adrenaline blocking drugs. Use of these combinations is usually best left to psychiatrists who are expert in the treatment of PTSD.

Related Reading:

Dunner, D. L. (1997). Current psychiatric therapy II (2nd ed.). Philadelphia, PA: W. B. Saunders Company.

4. Assessment and Management of PTSD in Children and Adolescents

Diagnostic Criteria

The PTSD criteria for symptoms include several modifications for children. Criterion A2 specifies that the extreme traumatic stressor may be experienced as producing intense fear, horror or helplessness **as well as** disorganized or agitated behavior in children. Currently, as with adults in order to receive a *DSM-IV* PTSD diagnosis child victims must exhibit at least one reexperiencing symptom, three avoidance/numbing symptoms, and two increased arousal symptoms ***(see Table 1 on page 46)***.

PTSD can manifest in a wide variety of clinical features in children. For this reason there is controversy among clinicians and researchers regarding whether or not the required number of symptoms in each *DSM-IV* category is appropriate and whether the current criteria adequately capture children's trauma responses, especially those of younger children ***(see AACAP, 1998, for discussion)***. The *DSM-IV* does specify that re-experiencing/ intrusive symptoms in children may be expressed as recurrent, generalized frightening dreams, repetitive posttraumatic play or trauma reenactment ***(see Criterion B, Table 1 on page 46)***. For example, elementary school-aged children may not exhibit certain characteristic features such as visual flashbacks but instead show posttraumatic reenactment of the trauma during their play, artwork, or verbalizations.

Commentators have observed that prepubertal children often experience sleep disturbances and may experience psychosomatic symptoms and omen formation (Benedek, 1985; Pfefferbaum, 1997; Terr, 1983). Very young children (i.e. infants, toddlers, and preschoolers) rarely meet full diagnostic criteria, in part because many criteria require verbal descriptions of internal states (Scheeringa, 1995). Instead they may present with generalized anxiety symptoms, sleep difficulties, and avoidance of particular situations. However, as children mature, they are more likely to present with PTSD symptoms similar to those experienced by adults. It is evident that developmental factors play a strong role in how PTSD is manifested in children and must be considered closely when considering a diagnosis and treatment plan. Many experts have suggested the need for a "developmental stage-specific diagnostic criteria" for PTSD in children and adolescents (AACAP, 1998, p. 14s).

Most children who experience traumatic events do not meet full diagnostic criteria, but a majority manifest some posttraumatic symptoms, especially emotional reactions to reminders of the event, fearfulness, sleep disturbance, and irritability. In addition, the severity of the trauma exposure, parental distress related to the trauma, and temporal proximity to the traumatic event have been found to consistently mediate the development of PTSD symptoms in children (Foy et al., 1996). It is the current consensus that children experiencing Criterion A events should be offered treatment, although they may not meet all of the strict *DSM-IV* components.

ASSESSMENT

The diagnosis of PTSD or the presence of PTSD symptoms in children and adolescents is based primarily on clinical interviews conducted with children and their caregivers. In cases where the caregiver is the alleged offender of the child abuse or partner violence (the index traumatic event), only the non-offending parent is routinely interviewed as part of the assessment process. The following recommendations are primarily based on the AACAP's (1998) practice parameters for the assessment of children and adolescents with PTSD.

1. Planning and Preparing for Assessments

See adult PTSD section on page 50.

2. Objectives of Assessment

The goal of assessment is to obtain a description of the traumatic event(s) and determine whether it was experienced with horror, fear or helplessness that can be expressed by agitation in children. The nature of the event, when it occurred and the degree of exposure to the event should be noted. The presence of the various symptoms is assessed. It is also important to learn about any preceding, concurrent, or more recent stressors in the child's life (e.g. child abuse/neglect, separation or divorce, frequent moves or school changes, family deaths, illnesses, substance abuse, exposure to domestic or community violence, caregiver's experience with serious trauma the child knows about) that might be accounting for PTSD symptoms.

Information is gathered both from the caretaker and directly from child victims. The developmental level of the child must be carefully considered when examining the variations in clinical presentation (e.g., non-specific nightmares versus reenactments of the trauma). Obtaining a report of the child's past psychiatric, medical and developmental history helps identify potential exacerbating factors. It is especially important to learn about the caregivers' emotional reactions to the traumatic event because this may substantially effect the child's presentation and trauma impact.

During the child interview, it is critical to use developmentally appropriate language to assess the child's understanding of the reasons for his/her referral, the child's trauma-related attributions and perceptions, and most importantly the child's report of present symptoms related to the trauma. Careful observation of the child's behaviors and responses will give the clinician a picture of the child's mental status and possible PTSD symptomatology.

It is also helpful in some cases to obtain information from school, daycare or other key sources to confirm certain symptoms or changes in behavior related to PTSD (e.g., changes in academic functioning, interactions with peers, presence or absence of ADHD symptoms before and after traumatic event). The clinician must be judicious in determining whether to consult outside parties because of the potential to compromise child confidentiality.

3. Assessment Strategies

There are various semi-structured diagnostic interviews schedules that have PTSD sections that have been used in research, however to date there is no single instrument accepted as a "gold standard" for making the diagnosis of PTSD or monitoring symptomatology. Table 4 on page 61 provides a list of several semi-structured interviews to assess PTSD in children and Table 5, on page 62, and 6, on page 63, summarize various child- and parent- report instruments that measure general and specific PTSD symptoms in children and adolescents, all of which are recommended by the AACAP (1998).

A variety of parent- and child- report measures can be informative and helpful in the assessment of PTSD symptoms across different areas of functioning, but they should **not** substitute for a careful and direct clinical interview. A semi-structured clinical interview can especially be of great help to clinicians inexperienced in assessing children for PTSD symptoms. Unfortunately, only three of the interviews listed below have been modified to correspond to *DSM-IV* criteria and none of these instruments have been rigorously psychometrically evaluated regarding the *DSM-IV* clinical diagnosis of PTSD.

TABLE 4: SEMI-STRUCTURED INTERVIEWS USED TO ASSESS PTSD IN CHILDREN AND ADOLESCENTS

Measures: Semi-structured Interviews	Source	*DSM* Version Used	Reliability & Validity Data
Schedule for Affective Disorders and Schizophrenia for School Age Children-Present and Lifetime version, PTSD scale.	Kaufman et al. (1997)	*DSM-IV*	High interrater reliability, good test-retest reliability
Diagnostic Interview for Children and Adolescents, PTSD	Famularo et al. (1996)	*DSM-III-R*	None
Diagnostic Interview Schedule, PTSD	Garrison et al. (1995)	*DSM-III-R*	None
Structured Clinical Interview for *DSM-III-R*, PTSD	Hubbard et al. (1995)	*DSM-III-R*	None
Clinician-Administered PTSD Scale for Children and Adolescents, *DSM-IV* version	Nader et al. (1996)	*DSM-IV*	Currently being evaluated
Childhood PTSD Interview-Child Form	Fletcher (1997a)	*DSM-IV*	High interrater reliability, strong construct and convergent validity

Key: PTSD= Post-Traumatic Stress Disorder

*Table adapted from AACAP (1998)

TABLE 5: INSTRUMENTS MEASURING ALL PTSD SYMPTOMS IN CHILDREN AND ADOLESCENTS

Measure & Source	Format	*DSM* Version Used	Reliability & Validity	Age
PTSD Reaction Index (Frederick, 1985; Goenjian et al., 1995; Pynoos et al., 1987)	20- item self-report; may also be used as semistructured interview	*DSM-III*	High correlation with clinical diagnosis	NS
Child PTSD Symptom Scale (Johnson et al., 1996)	17-item child interview	*DSM-IV*	High preliminary IC, test-retest R, & CV w/ Reaction Index	NS
Children's PTSD Inventory (Saigh, 1988, 1989; March, in press)	Self-report with 5 subscales (exposure, reexper-iencing, avoidance, hyperarousal, degree of distress)	*DSM-IV*	High interrater R, sensitivity & specificity of diagnosis, high correlation with clinical diagnosis	NS
Checklist for PTSD Symptoms in Infants and Young Children (Scheeringa et al., 1995)	Clinician-rated symptom inventory	*DSM-IV*	None	0-3 yrs
Posttraumatic Symptom Inventory for Children (Eisen, 1997)	30-item interview	*DSM-IV*	High IC, preliminary CV	4-8 yrs
When Bad Things Happen Scale (WBTH) (Fletcher, 1996b)	95-Item self-report	*DSM-IV*	High IC & CV	≥3rd grade
PTSD Checklist/Parent Report (Ford et al., 1996)	17-item parent report	*DSM-IV*	High IC, good IRR, strong CV & Construct V.	NS
Checklist of Child Distress Symptoms- (CCDS) Child Version. (Martinez & Richters, 1993)	25-item self-report	DSM-III-R	High IRV & CCV	6-17 yrs
CCDS- Parent Report (Richters & Martinez, 1990)	28-item parent report	DSM-III-R	High IRV & CCV	6-17 yrs
"Levonn" (A Cartoon-Based Interview for Assessing Children's Distress Symptoms) (Richters et al., 1990)	40-item self-report pictorial/visual thermometer rating scale in response to questions read to child	DSM-III-R	None	<6 yrs
Child Stress Reaction Checklist (Saxe et al., 1997)	35-Item parent, teacher, or medical staff report	DSM-IV	High preliminary IRR & Construct V	NS

Key: R = Reliability, V = Validity, IC = Internal Consistency, CV = Convergent Validity, CCV= Concurrent Validity, Interrater = IR, NS= Not specified

*Table adapted from AACAP (1998)

TABLE 6: INSTRUMENTS THAT MEASURE SPECIFIC ASPECTS OF PTSD IN CHILDREN & ADOLESCENTS						
Measure	**Source**	**Format**	***DSM* Version Used**	**Reliability & Validity Data**	**Age**	**Comments**
Trauma Symptom Checklist for Children	Briere, 1995	54- Item self-report	*DSM-IV*	High test-retest R & IC of subscales	8-17 yrs	Measures sequelae of trauma on 6 subscales; PTSD subscale primarily measures reexperiencing.
Children's Impact of Traumatic Events Scale	Wolfe et al., 1989	52-Item self-report	*DSM-III-R*	High IC & Independence of subscales	NS	Particularly applicable to SA children.
Child Sexual Behavior Inventory	Friedrich et al., 1992	45-Item self-report	*NA*	High test-retest R & IC	2-18 yrs	Measures repetitive sexualized behaviors specifically applicable to SA children.
Weekly Behavior Report	Cohen & Mannarino, 1996	22-Item parent report	*DSM-IV*	High test-retest R, IC, CV	3-7 yrs	Measures anxiety, avoidance, sleep problems, and preoccupation with sexual abuse-related words & behaviors; specifically applicable to SA young children.

Key: R = Reliability, IC = Internal Consistency, CV = Convergent Validity, SA= sexually abused, NS= Not specified.
*Table adapted from AACAP (1998)

Discussion

The inherent limitations in assessing PTSD in children primarily involve the fact that half of the *DSM-IV* criteria refer to internal emotional states. Children may not recognize or be able to articulate the criteria. Caretakers may not be aware of whether children are having intrusive thoughts, numbing or memory loss because there are no internal manifestations. In addition, children may not spontaneously report symptoms because they do not understand the importance of accurate diagnosis for effective treatment. There is also substantial evidence that parental distress and attributions effect the validity of their observations about children's emotional and behavioral states; they tend to under or over report certain symptoms.

Overall, there is consensus among experts regarding several critical parts of the assessment process. Standardized instruments should **not** be used to substitute a careful and directed clinical interview in assessing PTSD diagnostic criteria. Assessment measures can be helpful supplemental tools. Another important part of the assessment involves directly asking the children about PTSD symptoms relating to the traumatic event. Empirical and clinical evidence support asking them, for if they are not asked, they are less likely to talk about their PTSD symptoms and ultimately clinicians lack valuable data that could be helpful in determining a diagnosis and treatment plan.

TREATMENT STRATEGIES

Many writers have described trauma-specific treatment approaches for children who have been diagnosed with PTSD or who exhibit PTSD-related symptoms. These approaches have in common an emphasis on direct emotional and cognitive processing of the trauma. Although relatively few controlled treatment-outcome studies relating to children with PTSD have been conducted, there is strong clinical consensus among experts in the field regarding the **essential components of treatment for these children**. These include the direct exploration of trauma, the use of certain stress management techniques, exploration and correction of inaccurate attributions regarding trauma, and the inclusion of parents in treatment (AACAP,1998). Overall, most researchers and experts in the field believe some level of trauma-focused discussion to be the most significant component of treatment for PTSD in children, regardless of the specific approach by which the trauma is addressed.

Talking about what happened provides an opportunity for the child to discharge negative emotions and gain a more adaptive perspective. Avoidance of the subject may hinder successful processing and consume emotional and cognitive resources that would be better used on normal developmental processes. Early, focused intervention may avert the development of habitual avoidance coping that can lead to other problems including substance abuse, running away, or not directly confronting difficult life situations.

The inclusion of caregivers in treatment is considered an essential component of child victim therapy. For this reason, most of the recent studies have treated caregivers as well as children. The therapy approach with caregivers is similar to that for the children. It is believed that if caregivers process their feelings and gain an accurate view of the traumatic event, they will be better equipped to support and help their children. Including caregivers in treatment also facilitates the monitoring of the child's PTSD symptomatology. Treatment approaches with caregivers often include a psychoeducational component regarding their child's posttrauma symptoms and instruction on how to handle trauma-related behaviors in the child such as sleeping problems, fears, and regressive behavior.

To date, there is no clear evidence regarding the proper length of treatment for children with PTSD, although all proven treatments have been short term (10-18 sessions). Treatment length is dependent upon the child's unique symptomatology and progress in treatment. For example, a child who is exposed to prolonged victimization, has poor pre-morbid adjustment, presents with co-morbid conditions, and/or displays chronic PTSD symptoms with predominantly dissociative features may require much longer treatment (AACAP, 1998).

1. General Treatment Components

When clinicians offer assistance to traumatized children and their families, they should begin with:

1) Establishing rapport with the child and caregiver(s) and

2) Providing a rationale for treatment.

The clinician should keep the following points in mind when providing a rationale for treatment: The child and caregiver(s) should separately or together receive information regarding the purpose and process of treatment. Caregivers should be informed about the common effects of traumatic experiences on children; that children can have a variety of different reactions. Most children do not have lasting psychological effects (although with some experiences long term effects are more

likely, e.g., abuse by a parent, long-term abuse). Treatment will most often be relatively short term and will involve talking about what happened, learning to express feelings appropriately, and gaining an accurate perception of the event. The treatment rationale and concrete goals of therapy should be presented to the child in a clear and simple manner. In the case of certain crimes, such as sexual abuse or physical abuse, where there may be misinformation about children's roles in what happened or offender patterns, it is important to provide corrective information. Educating caregivers and their children about healthy sexuality and personal safety skills is also important during the initial phase of treatment with victims of sexual abuse.

2. Cognitive Behavioral Treatment (CBT)

Empirical evidence from controlled treatment-outcome studies provides the strongest support for the use of trauma-focused cognitive-behavioral treatment (CBT) to resolve PTSD symptoms. Therefore, CBT may be considered as the first line approach, either alone or in conjunction with other forms of therapy (AACAP, 1998). CBT usually involves the following components: direct discussion of the trauma, emotional and cognitive coping skills, correcting cognitive distortions, and contingency reinforcement programs for children displaying behavioral problems. The current consensus is it is not necessary that children be diagnosed with PTSD to receive this treatment, only that they have identifiable posttraumatic stress symptoms that interfere with functioning. CBT approaches are based on the interrelationship between thoughts, feelings and behaviors. In many cases thoughts can lead to emotional states which in turn produce behavioral responses. For example, traumatized children may have overgeneralized or inaccurate beliefs derived from the crime experience that triggers anxiety responses. Anxiety is expressed as intensely uncomfortable or may be expressed in appropriate behaviors. In addition, avoidance coping may temporarily reduce anxiety but lead to maladaptive behavior patterns.

CBT Techniques

Primary Resources:

American Academy of Child and Adolescent Psychiatry (AACAP). (1998). Practice parameters for the assessment and treatment of children and adolescents with PTSD. Journal of the American Academy of Child & Adolescent Psychiatry, 37 (Suppl. 10), 4s - 26s.

Deblinger, E., & Heflin, A. H. (1996). Cognitive behavioral interventions for treating sexually abused children. Thousand Oaks, CA: Sage Publications.

Ruma, C. D. (1993). Cognitive-behavioral play therapy with sexually abused children. In S.M. Knell (Ed.), Cognitive Behavioral Play Therapy (pp.197-230). Northvale, NJ: Jason Aronson Inc.

A. Teaching Stress Management Techniques

Stress management techniques such as progressive muscle relaxation, thought-stopping, positive imagery, and controlled breathing are often taught to accompany direct trauma-focused discussion in treatment. It is usually recommended that these skills be taught to children prior to detailed discussions of the trauma. With practice, relaxation strategies can help the child gain confidence to approach the direct discussion of the trauma without overwhelming fear, as well as handle other stressful situations outside of the therapeutic context (i.e. flashbacks at school). Relaxation and breathing techniques can be enjoyable to learn and do. Because stress management is a useful skill and is easy to master, this component of treatment can facilitate a more positive association to therapy to counterbalance some of the more difficult aspects.

1. Relaxation Techniques

Systematic relaxation consists of a series of muscle tensing and relaxation exercises. Progressive relaxation & guided tension releasing exercises are recommended for

children above 10 years. Therapists may want to adapt exercises to the child's most problematic muscle groups or focus on head, torso and leg exercises separately.

Image-induced relaxation is a strategy that may be more effective for younger children. They are taught to distinguish between tense and relaxed states. For example, a child is asked to stand like a "tin soldier" and conversely collapse like a "wet noodle" into a chair. Children are taught when confronted by distressing memories or cues to practice relaxed responding. Children are taught self-instruction such as 'relax, hang loose, lighten up, or calm down' at these times and is encouraged to practice at home.

Controlled / deep breathing consists of gradually breathing in and out on a count of four to restore normal breathing states and promote relaxation. This technique can be used in vivo for all types of stress inducing situations.

2. Cognitive Coping Techniques

Thought replacement consists of teaching children to interrupt upsetting or disturbing thoughts (e.g., imagines a stop sign and sub-vocalizes the word STOP), and focus on a positive experience or memory (e.g., getting hugged by a parent, going to Disneyland).

Positive coping self-statements challenge the disturbing thoughts with self affirming or reassuring thoughts (e.g., I am strong, I can handle this situation, I am not really in danger now).

B. Direct Exploration / Discussion of the Traumatic Experience

There is a strong clinical consensus that addressing the traumatic experience, regardless of the specific methodology, is the core ingredient of effective treatment for PTSD in children. Exposure to the traumatic memories and feared reminders under safe circumstances serves to decondition these associations and reduce the use of avoidance coping. Safety does not just mean that the child has developed trust in the therapy environment. Most important is that the child is in a safe and supportive living situation. **It is inappropriate and possibly dangerous to encourage children to engage in trauma-focused therapy when they are still at risk**.

1. Exposure Techniques

For children, ***gradual exposure techniques*** are recommended. However, there are case studies of the use of PE/flooding with traumatized adolescents. These techniques gradually expose a child to thoughts, memories and other cues or reminders of the traumatic experience. When children can tolerate the memories without significant emotional distress they are less likely to resort to avoidant behaviors. The goal is that when children face trauma-related memories or cues, more adaptive responses like feelings of control, mastery, pride and courage will gradually replace fearful/anxious responses.

There are a variety of different exposure techniques used to elicit children's participation and provide them with a sense of control. It is important, regardless of the exposure technique used, that a therapist clearly presents to the child the rationale behind exposure. For example, a therapist may use the "cold swimming pool" analogy and explain how at first getting in is hard and hurts because the water feels freezing and gradually it gets better and finally feels fine. The therapist then relates this experience to thinking and talking about the traumatic event(s)" (see Deblinger & Heflin, 1996 for a complete example dialogue, p. 45-47). No matter how well a therapist prefaces the exposure procedure, resistance by children may be an initial reaction to this therapeutic approach because significant emotional and physical discomfort may be experienced.

For this reason it is important to inform caregivers and children that some increased symptoms are common responses at first. In order to attain relief in the long run, some level of anxiety or distress may need to be endured while confronting fears. Preparing caregivers for children's possible negative reactions to therapy will increase cooperation and compliance.

Gradual exposure techniques are primarily designed to be useful when posttraumatic stress symptoms are present. Children who do not exhibit fear or anxiety may not need extensive focus on the traumatic experience itself. Emotions such as embarrassment, shame, or sadness associated with recalling the event may be reasonable reactions or may be better addressed through a focus on attributions and perceptions about the event. A child's symptoms may worsen if a therapist insists upon constantly talking about the traumatic memories or events. There is currently no evidence that talking about the details of what happened is necessary for recovery in all children.

In sum, a child's capacity to talk about the trauma without experiencing significant distress or use of avoidance coping is an indication of successful emotional processing. However, a child's unwillingness to talk about it may not be because of a posttraumatic stress reaction but instead a legitimate response (e.g., tired of talking about it, embarrassed). In these situations, various indirect methods of addressing trauma-related issues like art, book making and play techniques may be more useful. Mediums such as clay or PLAY-DOH® can also facilitate children in depicting different aspects of the traumatic event (Ruma, 1993).

2. Strategies for Gradual Exposure

Developing a Fear Hierarchy: The child and therapist collaborate to develop a fear hierarchy wherein trauma-related reminders and memories are placed in order from least to most distressing. The process of gradual exposure begins by confronting the least anxiety provoking stimuli first and works its way through more distressing stimuli (e.g. the child might identify hearing the word "rape" as upsetting, but less so than remembering what actually happened). Talking, writing, speaking into a tape-recorder, responding to a "mock interview," or drawing a picture with explanation can be used to accomplish exposure. Role-playing, puppet play, and doll-play can be helpful especially with young children. Some children may choose to create books, poems or songs about their traumatic experiences (Deblinger & Heflin, 1996; Ruma, 1993).

Direct Exposure: This method is appropriate for an older child with good visualization skills. The child is asked to recall specific sensory details of traumatic event, focusing on visual memories. Fantasy is discouraged when recalling the account. This approach should not be confused with hypnotic suggestion or guided imagery. For example, a therapist asks the child to close her eyes (if comfortable) and recall a scene of the traumatic event as if she were there. The therapist poses some specific questions to help the child stay focused like, "describe the room you were in, the time of day, or what the child smells, hears, feels, and thinks at the time." Too many questions may interfere with the child's visualization. The therapist should only ask as many questions as they feel necessary to help the child visualize the scene. The session should not end until the child's anxiety level has decreased or coping techniques have been used to help the child regain a sense of calmness.

In Vivo Exposure: This technique is most often used in the later stages of the exposure therapy. The child is helped to identify situations for **in vivo** practice of exposure to fear inducing stimuli. This should occur in a situation where there is no actual danger or risk thus enabling the child to experience mastery and competence (e.g., confronting fear of the dark by turning off the light during the session, sleeping alone in her room, walking to school).

C. EXPLORING AND CORRECTING INACCURATE ATTRIBUTIONS

Most interventions for traumatized children also involve the evaluation of cognitive assumptions children may have made relating to the traumatic experience. Children make sense of their experiences in the world by developing belief systems. Like adults, most children have a generally positive view of themselves, other people and the world. Being the victim of a crime can conflict with these beliefs. In order to resolve the conflict, children may change their ideas and thoughts about themselves and others or develop inaccurate, distorted and confused beliefs about the trauma. Examples of faulty attributions are "Nothing is safe anymore", "It was all my fault", "I must be a bad person for this to have happened." For some children, unfortunately, a traumatic event can serve to confirm already existing negative perceptions.

When treating children with PTSD, it is important to explore and correct these distorted thought patterns related to the trauma. The maladaptive assumptions or beliefs must first be identified. This means it is important initially to allow children to express beliefs even though they may be inaccurate (e.g., self blame- "I asked for it because I went to his house"-or thinking that drinking caused the offender to abuse). Then through various therapeutic exercises, like role playing, telling stories, and providing corrective feedback, these negative or inaccurate thoughts can be disputed. The therapist helps the child generate positive thoughts to replace negative or distorted ones instead of just telling children what they should think. With younger children, play therapy using toys and dolls, art materials, and games may be a more effective approach to explore their inaccurate attributions.

Strategies for correcting cognitive distortions

Cognitive Coping Triangle: The therapist facilitates discussion with the child about the interrelationship among thoughts, feelings and behavior starting with a general discussion and moving toward trauma-specific examples. Using examples from every day life is a useful way of conveying these connections and then relating them to posttraumatic symptoms. For example, the child is presented with a negative and a positive scenario involving peers. For each situation, the child is asked what his/her thoughts, feelings and behaviors would be. The child practices identifying the emotions generated by different thoughts and then identifying thoughts underlying emotions. The therapist helps the child work through examples modeling the process and pointing out how different thoughts about the same situation can result in very different feelings and behaviors.

This process may be difficult. Visual aids like pencil and paper, a chalkboard, or a dry-erase board are used to help work through fictitious examples until the child understands the problem triangle concept. (See Deblinger & Heflin, 1996 p. 60-64.)

Disputing negative/unproductive thoughts: The therapist explains that changing distressing thoughts and emotions is a skill that can be gradually acquired through practice. The therapist stresses that negative thoughts are **not** necessarily valid or permanent. The therapist presents fictitious examples through storytelling in which the child practices substituting positive replacement thoughts for negative unhealthy ones. For example, the therapist may use the "Best Friend Role Play" in which the child role plays with therapist, (or puppet, empty chair, etc.) imagining that their best friend is having negative thoughts and their job is to convince the best friend that these thoughts are **NOT** true. It is important to distinguish between the personal thoughts and feelings of therapist and the role that they are playing during these exercises. For younger children, the use of a puppet reinforces the idea that they are engaged in a game and distinguishes the character's beliefs in the role-play from the therapist's beliefs (See Deblinger & Heflin, 1996, p. 66-67).

Generating Positive Self-Statements: The therapist teaches the child a series of positive self-statements that can replace negative dysfunctional thoughts. Children's self-statements are made to fit their individual difficulties. For example, a child with low self esteem and poor self-image may be encouraged to say *I am just as good as other kids* or generate reasons why they are special. A withdrawn and/or fearful child may be taught to say *It's fun trying new things* or *I am very brave sometimes*.

OTHER TREATMENT MODALITIES

A variety of other therapeutic modalities used to treat children with PTSD have been described in the clinical literature. The most prominent approach is play therapy. Elaine Gill is considered the leading proponent of trauma focused play therapy (Gill, 1991). This play therapy is usually characterized by using modified versions of play and other non-verbal methods to address the traumatic experience in contrast to the traditional non-directive, interpretative model of play therapy. It shares with CBT interventions a focus on the traumatic experience and may indirectly provide an opportunity for exposure.

Psychoanalytic/psychodynamic interventions for traumatized children have been described in some clinical case examples and are characterized by longer term, individual therapy to address the impact and meaning of the trauma. Friedrich (1996) has described a more eclectic approach for sexually and physically abused children. His integrated model of psychotherapy focuses on three main elements: (1) attachment, (2) behavior/emotion regulation and (3) self-perception. Some examples of goals of this approach involve the therapist establishing a strong therapeutic alliance with the child; providing structure, predictability and a clear rationale and definition of the therapy process; and, stressing the importance of disclosure and discussion of the traumatic event. Helping the child improve their sense of self-efficacy, mastery and competency are important therapeutic goals (Friedrich, 1996).

EMDR has shown promise for reducing PTSD symptoms in adult sufferers. One study (Chemtob, Nakashima, Hamada, & Carlson, under review) of treatment resistant children following a natural disaster showed improvement with EMDR compared to no treatment, however, there is no published literature on its use with child crime victims.

Co-morbid Disorders and Treatment Issues

Posttraumatic stress symptoms are not the only impacts of traumatic experiences on children and PTSD treatment approaches may not be sufficient for other symptoms or co-morbid disorders. Studies are equivocal with regard to the effectiveness of PTSD approaches for depression and general behavior problems. Some studies have shown that the trauma-focused CBT treatments also reduce depression and behavior problems. It is not clear whether the benefit is from the trauma-specific components or from the treatment that the parents have received. One way to proceed is to see whether comorbid symptoms improve with the trauma-focused PTSD treatment and if they do not, to change the treatment focus or use treatments that have been found effective for these disorders. No studies have specifically addressed the effectiveness of treatments for children's dissociative symptoms like partial amnesia, depersonalization and derealization.

Pharmacotherapy

Preliminary studies have shown that some children with PTSD present with physiologic abnormalities much like those seen in adults with PTSD (e.g., Perry, 1994). Even though randomized trials have not yet been conducted, preliminary reports have prompted clinicians to use a variety of medications with children suffering from PTSD symptoms and associated symptoms of depression or panic. The psychopharmacological agents that have been recommended include propranolol, carbamazapin, clonidine, and antidepressants (see AACAP, 1998). Most often these medications are not considered the primary intervention but prescribed in conjunction with psychotherapy.

Research on psychopharmacological treatments for children with PTSD have revealed that certain psychotropic medications have significantly reduced reexperiencing symptoms like nightmares and other PTSD related symptoms in uncontrolled clinical trials. However, there is insufficient empirical support for the use of any particular medication to treat PTSD symptoms in children at this time (March et al., 1996). Clinicians must judiciously determine which psychopharmacologic interventions are most appropriate for children with PTSD suffering from prominent depressive, anxiety, panic, and/or ADHD symptoms. As a general practice, "medication should be selected on the basis of established practice in treating the comorbid condition (e.g., antidepressants for children with prominent depressive symptoms)" (AACAP, 1998, p. 18s). Due to their favorable side effect profile and effectiveness in treating both depressive and anxiety disorders, serotonin reuptake inhibitors (SSRIs) are often the first psychotropic medications selected for treating pediatric PTSD. Imipramine also is often chosen to treat children suffering from comorbid panic symptoms (AACAP, 1998).

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C. DEPRESSION IN ADULTS, CHILDREN AND ADOLESCENTS

Much of this guideline is based on existing guidelines for clinical practice developed by the Agency for Health Care Policy and Research (AHCPR) Depression Guideline Panel (Rush et al., 1993a; 1993b); The American Psychiatric Association Depression Guideline Panel (APA, 1993); and, the American Academy of Child and Adolescent Psychiatry's (AACAP) Practice Parameters for the Assessment and Treatment of Children and Adolescents with Depressive Disorders (AACAP, 1998).

1. INTRODUCTION -- EMOTIONAL AND PHYSIOLOGIC MANIFESTATIONS OF DEPRESSIVE DISORDERS

Depression is a symptom of several disorders that can range from mild to severe, and from transitory to chronic. The onset of depression can occur at any age and may be triggered by a single event or a series of events. These events may be experienced as traumatic or insignificant at the time and usually require careful clinical assessment to be fully understood. Anyone who has been the victim of a crime is likely to experience the event as upsetting or traumatic and, therefore, may experience some depressive symptoms. Depressed mood alone does not constitute a depressive disorder. Depression as a mood disorder in adults can include a variety of emotional and physiologic symptoms. These are summarized below and the *DSM-IV* (1994) diagnostic criteria for depression is presented in Table 1 on page 78.

In the **emotional arena,** symptoms can be expressed verbally or non-verbally, and can include: sadness, tearfulness, low self-esteem, obsessive self-critical thoughts, inability to experience pleasure, loss of ambition, loss of interest, indecisiveness, inability to concentrate, irritability, anxiety, anger, pessimism, guilt, helplessness, hopelessness, and suicidal fantasies. Any one or more of the emotional states listed above may be the primary emotional state of a person suffering from depression, not just sadness.

In the **physiologic arena**, symptoms can include: fatigue, insomnia, increased need for sleep, increase or decrease in appetite, anorexia, digestive problems, constipation, social withdrawal, sexual dysfunction, and hypochondriasis.

For children and adolescents, the clinical manifestation of depression varies across developmental stages and diverse ethnic groups, but is generally analogous to adult symptoms ***(see Table 1, page 78)***. When compared to adults, children and adolescents generally present with more symptoms of anxiety (e.g., phobias and separation anxiety), somatic complaints, auditory hallucinations and increased irritability. Instead of verbalizing feelings, children may express increased irritability and frustration through temper tantrums and behavioral difficulties. Children have fewer delusions and fewer serious suicide attempts than adults; this is attributed to the lack of cognitive maturation in children. In middle to late childhood, children report more cognitive components of their depressed mood, as well as low self-esteem, guilt, and hopelessness. Adolescents tend to experience more sleep and appetite disturbances, delusions, suicidal ideation and attempts, and impairment of functioning than younger children, and more externalizing behavioral problems than adults.

TABLE 1: DEPRESSIVE DISORDERS DSM-IV DIAGNOSTIC CRITERIA

Major Depressive Disorder (MDD), *Single Episode* Criteria 296.2x

A. Presence of a single **Major Depressive Episode**:

(1) At least 5 of the following **symptoms** must be present every day or nearly every day during the same **2-week period** and represent a change from previous functioning.

(2) At least one of the symptoms is either:
- depressed mood or
- loss of interest or pleasure

Symptoms: ≥ 5

(1) Depressed mood most of the day, as indicated by either subjective account or observation by others. **In children & adolescents**-mood can be irritable.

(2) Markedly diminished interest or pleasure in all, or almost all, activities.

(3) Significant weight loss when not dieting or weight gain, or decrease or increase in appetite. **In children**-consider failure to make expected weight gains.

(4) Insomnia or hypersomnia.

(5) Psychomotor agitation or retardation (observable by others).

(6) Loss of energy or fatigue.

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional).

(8) Diminished ability to think or concentrate, or indecisiveness.

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation w/o a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The Major Depressive Episodes are *not* better accounted for by Schizoaffective DO & is not superimposed on Schizophrenia, Schizophreniform DO, Delusional DO, or Psychotic DO NOS.

C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

Key: DO = disorder, NOS = Not Otherwise Specified

TYPES OF DEPRESSIVE DISORDERS

Depression may signal both a single primary disorder or a combination of disorders (e.g., dysthymia and major depressive episode). The conditions which may underlie depression must be carefully evaluated to determine what the depression means in a given person. Since there is no comprehensive guide to the types of depression most prevalent in crime victims, all possible diagnostic meanings of the depression must be considered. A crime is a stressful event that can trigger a depressive disorder. Other factors that may increase the likelihood of a depressive disorder as the result of a crime include: family history of depressive disorders(s), individual history of depressive disorder(s), suicidal thoughts or attempts, lack of a social support network, and current or past drug abuse. Women are twice as vulnerable to depression as men.

The major categories of depressive disorders, briefly defined below, include:

1) **Adjustment Disorder with Depressed Mood (or Mixed Anxiety and Depression)**
2) **Dysthymic Disorder**
3) **Bipolar Disorder**
4) **Cyclothymic Disorder**
5) **Major Depressive Disorder (MDD)**

Depressive disorders can also be described differently in diverse cultures, such as "nerves" or headaches in Latino cultures, "imbalance" in Asian cultures, and "heartbroken" in some Native American cultures.

1. Adjustment Disorder with Depressed Mood (or Mixed Anxiety and Depression):

Depressive symptoms or depressive symptoms mixed with anxiety that develop within 3 months in response to an identifiable stressor or stressors. Prevalence of this disorder, as the primary diagnosis, is approximately 5 % - 20 % in men and women (DSM-IV, 1994). This condition is by definition acute and generally treatable within six months of onset. Continuing stressors may lengthen the persistence of the Adjustment Disorder. Depressive symptoms in Adjustment Disorder are higher than the precipitating event would logically engender and there is impairment in social or work functioning to some degree. Treatment generally consists of psychotherapy with occasional short-term use of psychotropic medication. The diagnosis of Adjustment Disorder does not apply when the symptoms represent bereavement. Children with this disorder tend to experience extreme mood fluctuations and impairment of functioning within the three months following the identifiable stressor, however, they do **NOT** meet diagnostic criteria for MDD. Overall, this disorder is associated with less severe mood disturbance, fewer symptoms and no relapse.

2. Dysthymic Disorder (DD):

Chronically depressed mood that is present most of the time for at least two years for adults and one year in children. This disorder affects approximately 6% of the population, more specifically 4% of women and 2% of men (APA, 1994; Rush et al., 1993a). Depressed mood is not substantially affected by outside stressors. Eating and sleeping disturbances are common. Identity is linked to depressed mood, and depressed feeling is experienced as normal. Course of treatment varies, depending on presence of acute episodes of major depression and degree to which productivity and functioning are impaired. Treatment may typically include a combination of psychotherapy and psychotropic medication. Dysthymic Disorder often occurs in combination with Major Depressive Disorder or Personality Disorder. Children with DD may manifest irritable mood instead of depression. Other symptoms such as feelings of being unloved, anger, self-deprecation, somatic complaints, anxiety and disobedience have been noted in children. Fewer children than adolescents suffer from this disorder.

3. Bipolar Disorder:

This disorder is marked by one or more episodes of manic mood which may include elation; grandiosity; illogical and/or psychotic thought processes; pressured speech; decreased need for sleep; increased sociability; distractibility; flight of ideas; impairment in functioning (especially in structured situations like work); lowered frustration tolerance; promiscuity; assaultive and/or criminal behavior; and, significant deficits in judgment. Behavior is impacted more seriously than in hypomanic moods which have many of the same symptoms. These episodic moods may alternate with mild to severe depressed moods. The classic type of Bipolar Disorder is a mixture of mania and Major Depressive episodes. Lifetime prevalence of this disorder is 0.4% - 1.6% for both men and women. Bipolar Disorder usually begins before age 30. Not all types of Bipolar Disorder include psychotic process. Manic episodes can vary in duration and interval between episodes but generally occur one to four times a year and without treatment last less than a week. Course of treatment for acute manic episodes is generally less than three months and includes medication, and when appropriate, psychotherapy.

The nature and course of Bipolar Disorder in children is not yet fully understood and is currently the subject of some controversy. The primary issues concern whether rapid or ultra rapid mood cycling and significant difficulties in affective dysregulation constitute the same disorder that is seen in adults, or leads to Bipolar Disorder as manifested by adults. It is also especially important that developmentally normal variations in mood fluctuations and impulsivity not be characterized as evidence of the disorder.

4. Clyclothymic Disorder:

This disorder is a mild form of Bipolar Disorder and includes hypomanic, as opposed to manic, episodes; depressed mood, as opposed to major depressive episodes; and does not include psychotic process. Cyclothymic disorder may become a Bipolar Disorder. A two-year period of less extreme fluctuating moods without clear internal or external triggers is necessary to make this diagnosis. Prevalence of this Disorder is 0.4% for men and women. Treatment may include psychotherapy and psychotropic medication.

5. Major Depressive Disorder (MDD):

This disorder is characterized by severe ongoing depressed mood; loss of pleasure in activities; changes in appetite and sleep; decreased energy; lowered self-esteem; self-critical thoughts; inability to feel happy, sad or to have feelings in general; feelings of guilt; irritability; psychotic thoughts; indecisiveness; sexual dysfunction; feelings of sadness or despair; thoughts of death; suicidal thoughts; and, impaired functioning in relationships or at work. A Major Depressive Episode cannot be diagnosed during the first two months after the death of a loved one. The symptoms of MDD can vary significantly but must include loss of pleasure and, usually, decreased appetite and insomnia. This disorder afflicts 10 - 25% of all women and 5 - 9% of all men during the life cycle. Treatment of an acute episode of MDD includes medication, psychotherapy, and at times help with daily life tasks.

MDD affects approximately 2% of children and 4-8% of adolescents. The male-female ratio is 1:1 in early childhood but 1:2 by adolescence (Birmaher et al., 1996a). It is not clear why girls are twice as likely to suffer from depressive disorders as boys in adolescence, but it has been hypothesized that girls carry more risk factors for depression than boys. For example, girls tend to use more ruminative and self-focused problem solving styles than boys, worry more about their body image and deal earlier with the psychosocial and biological consequences that accompany puberty.

Co-morbidity in Adults

Although there is no epidemiologic study of depression in the wide spectrum of crime victims, some well-established findings gathered from trauma survivors with Post-Traumatic Stress Disorder {PTSD} (e.g., survivors of war, massive traumas, and natural disaster) would presumably apply. Studies have consistently shown that depression, along with generalized anxiety, is one of the most common co-occurring diagnoses with PTSD; in fact, almost half of adults suffering from PTSD also suffer from depression (Kessler et al., 1995). Co-morbidity with PTSD would be expected for depression due to the overlap in symptom criteria; for example, *DSM-IV* criteria C and D PTSD symptoms (e.g., diminished interest, restricted range of affect, sleep disturbances, difficulty concentrating) overlap with several of the hallmark symptoms of depression. Substance abuse, as well as eating disorders and obsessive-compulsive disorders, are not uncommon among individuals suffering from depression. Separate studies of spousal death or individuals who have experienced physical or sexual assault suggest a significant number (30%) will meet criteria for depression during the first year of recovery (Jones, 1993). If these depressions begin immediately after the death or assault they are at a greater risk of persisting and creating dysfunction.

CO-MORBIDITY IN CHILDREN

The majority of children with depressive disorders suffer from other psychiatric disorders; in fact, 40-90% of youth with MDD have other psychiatric disorders with 20-50% having two or more co-morbid diagnoses (AACAP, 1998; Birmaher et al., 1996a). Studies with traumatized children (e.g., sexually abused, natural disaster survivors) have revealed that depression often accompanies PTSD symptoms. For example, in a recent study, McLeer et al. (1998) found that of 80 sexually abused children, 36.3% were diagnosed with PTSD, and of that group, 13.8% were diagnosed with co-morbid major depression and 10.3% with dysthymia. The other most frequent co-morbid diagnoses include anxiety disorders, disruptive disorders, and substance use disorders. Younger children more commonly manifest Separation Anxiety Disorder, while comorbid substance abuse, conduct disorder, social phobia and general anxiety disorder are more common in adolescents. Substance abuse and conduct disturbances tend to appear **after** the onset child MDD and may persist after depression remits. Studies have revealed that depressed children who present with co-morbid disruptive disorders tend to have worse short-term outcome, fewer melancholic symptoms, fewer recurrences of depression, yet a higher incidence of adult criminality, more suicide attempts, higher levels of family criticism and response to placebo.

Overall, co-morbid disorders in depressed children raise concern because they appear to influence risk for recurrent depression, duration of the depressive episode, suicide attempts or behaviors, and responses to treatment and mental health service utilization. There is also particular concern for children suffering from double depressions (MDD and DD) and co-morbid anxiety and depression; these children often present with more severe, longer lasting depressive symptomatology, increased risk for substance abuse, increased suicidality, poor response to treatment, and more psychosocial problems.

CONCEPTUAL MODELS OF DEPRESSION: DYNAMIC VS. ADYNAMIC

While depression is an ubiquitous clinical problem, there is no objective way to diagnose it beyond the self report of sometimes non-specific signs and symptoms. With the introduction of the DSM classification of psychiatric disorders in the 1980's, an **adynamic** system which defined depression as an aggregation of clinical signs and symptoms was adopted. By themselves these signs and symptoms are non-specific, but their combination over a long enough period of time suggests a threshold or "criteria" for the diagnosis of depressive disorders ***(see Table 1 on page 78 and the following section on diagnosis)***. There is a longer standing **dynamic** concept of depression--that depressive signs and symptoms comprise a maladaptive response to a significant loss or to a fixed image of self as inadequate, helpless and blameworthy. It is appropriate to begin with a presumption that anyone who has experienced a serious criminal assault, rape or the homicide of a family member is presenting with a **dynamic** response. Signs or symptoms of depression should be viewed in the context of the occurrence of a traumatic event. Sadness, hopelessness, insomnia, self deprecatory ideation, etc. will thus bear some connection to the persistent memory of the crime. This should not exclude the possibility that depression as an **adynamic** disorder may also intervene. These two conceptual models of depression need not be mutually exclusive. This document will present guidelines for assessment and management of depression that will include both conceptual models that will combine psychologic and psychopharmacologic therapies.

2. ASSESSMENT AND MANAGEMENT OF DEPRESSIVE DISORDERS IN ADULTS

DETECTION, DIAGNOSIS & ASSESSMENT

The recognition and diagnosis of depression depends upon a clinician's awareness of risk factors for depression, as well as presence of key signs, symptoms and history of illness. Because effective treatment rests on accurate diagnosis, a systematic approach to the identification of depressive disorders is recommended. Self-report questionnaires can be extremely useful in screening individuals with significant depressive symptoms that should be further explored and evaluated through clinical interview.

The clinical interview has been found to be the most effective method for detecting depression because it allows the clinician to assess the criterion symptoms for depressive disorders and determine whether the symptoms are of sufficient intensity, number, and duration to meet the *DSM-IV* criteria. Once a clinician suspects or diagnoses a depressive disorder, it is recommended to conduct and record the results of a mental health status examination assessing suicidal risk and other domains of social, psychological and physical functioning. However, **before** conducting extensive biologic, neuro-psychological, or psychological testing, a clinician should spend considerable time carefully interviewing the client and, when appropriate, other informants/caretakers. In other words, the use of psychological and neuropsychological tests are **not** recommended for routine use in screening for depressive disorders. In certain cases, however, these tests may be extremely useful in differential diagnosis of depression.

Diagnostic Instruments

There are a variety of easy to administer, cost effective client self-report measures and clinician-completed scales readily available to practitioners. Meichenbaum (1994) and Smith, Mosley, & Booth (1996) profiled some of the most widely accepted self-report and diagnostic instruments used by clinicians to screen individuals for depression in primary care settings; some of these are listed in Table 2 below.

TABLE 2: DIAGNOSTIC INSTRUMENTS

Self-Report Instruments	**Diagnostic Tools**
(For screening individuals for depression in primary care settings):	***(These scales require a trained interviewer to administer):***
1. General Health Questionnaire (GHQ) (Goldberg, 1972) **2.** Beck Depression Inventory (BDI) (Beck et al., 1961; Beck, 1972) **3.** Zung Self-Rating Depression Scale (ZSRDS). (Zung, 1975) **4.** Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977)	**1.** Diagnostic Interview Schedule (DIS) (Robins et al., 1981) **2.** Hamilton Rating Scale for Depression (HRSD) (Hamilton, 1986) **3.** Inventory of Depressive Symptomatology—Clinician Rated (IDS-C) (Rush et al., 1986; Rush et al., 1996)
Client Self-Report Measures	
1. Inventory to Diagnose Depression (IDD) (Zimmerman, Coryell, Stangle et al., 1987)	
2. The Depression Outcomes Module's (DOM) Depression-Arkansas Scale (D-ARK) (Smith et al, 1994)	
3. Inventory of Depressive Symptomatology—Self Report (IDS-SR) (Rush et al., 1986; Rush et al., 1996)	

General Treatment Overview

The five formal treatments for adults with depressive disorders include pharmacotherapy, psychotherapy, a combination of both, electroconvulsive therapy (ECT) and light therapy. Medications have been shown to be effective in all forms of depression, yet no one antidepressant medication is clearly more effective than another and no single medication results in remission for all patients. Some patients cannot tolerate medications due to physical conditions, some simply do not wish to take medications or do not respond to medication, and others may request psychotherapy as the first-line treatment. Psychotherapy alone may reduce the symptoms if the depression is mild to moderate, nonpsychotic, not chronic and not highly recurrent. The combination of medication and psychotherapy may prove beneficial to individuals with a history of chronic psychosocial problems who have responded **partially** to either medications or psychotherapy alone, and/or with a history of treatment adherence difficulties. Medication is indicated for severe and psychotic depression. ECT is indicated for patients suffering from severe or psychotic forms of depression with intense, prolonged symptoms associated with neurovegetative symptoms; for patients who are significantly functionally impaired who have not responded to adequate trials of medications or other therapies, or cannot tolerate medications; and, those who are at an imminent risk for suicide. Light therapy is considered for mild to moderately severe forms of seasonal, nonpsychotic, depressive winter episodes.

Crime-Specific Treatment for Depression

Currently, there is no literature on the treatment of depression specific to crime victims. However, many studies have shown that trauma-specific treatment approaches (e.g., focusing on posttraumatic stress symptoms like avoidance and reexperiencing while addressing cognitive distortions) used with individuals suffering from posttraumatic stress symptoms are effective in reducing concurrent depressive symptoms. It is recommended that a trauma-specific approach be initially used for individuals displaying depressive symptoms. If the individual does not experience relief of depressive symptoms, then a more specific psychotherapeutic approach, e.g., Cognitive Behavioral Therapy (CBT) or Interpersonal Therapy (IPT), is indicated. The rationale for the use of CBT to treat depression is based on the idea that depressed patients have a distorted view of themselves, the world, and the future. CBT techniques aim to identify and counteract these cognitive distortions and misattributions. The IPT approach aims at clarification and resolution of grief-related problems, interpersonal roles, role disputes and transitions, and interpersonal difficulties. Presumably the mild depressive syndromes associated with grief and trauma distress will be focused on the memory of the crime. Symptoms will be less pervasive and will be addressed by the individual or group therapy that focuses on the grief and trauma. One study illustrates that grief related symptoms in recently bereaved widows are categorically distinguishable from depressive symptoms that show differential responses to treatment, and antidepressant medication improves symptoms of depressive disorders without any effect on the grief related (dynamic) symptoms in these depressed, grief stricken subjects (Pasternak et al., 1991). This study highlights the intuitive clinical wisdom of remaining flexible and inclusive with clinical interventions.

Pharmacotherapy should always be considered for victims who meet criteria for Major Depressive Disorder, Psychotic Depressive Disorder or Bipolar Disorder; those who present with severe and disabling depression that has lasted more than three months; and, those who have a previous history of treatment for depression and present with lethal suicidal intent. These patients should be considered for psychiatric consultation and consideration of pharmacologic management on an inpatient or outpatient basis. People with severe and disabling depression will not be responsive to psychotherapy alone.

3. ASSESSMENT AND MANAGEMENT OF DEPRESSIVE DISORDERS IN ADOLESCENTS AND CHILDREN

Very little evidence-based research has been conducted on child and adolescent depressive disorders. Most of the studies regarding treatment and efficacy data have been based on clinical experience or have involved adults. None of the research has specifically involved child or adolescent victims of crime. Therefore, caution should be used when applying adult research to children.

The current literature on depressive disorders in children reveals that Major Depressive Disorder (MDD) is the most studied of all depressive disorders in children. However, this does not establish that MDD is the most common type of depressive disorder in children. Children and adolescents may present with a variety of depressive symptoms which may meet criteria for Adjustment Disorder, a Cyclothymic Disorder, a Dysthymic Disorder, or a MDD. In many cases, the symptoms do not meet the full criteria but still result in significant subjective distress and impairment.

DETECTION, DIAGNOSIS & ASSESSMENT

Depressive disorders in youth are often recurrent and accompanied by co-morbid conditions, poor psychosocial outcome and high risk of suicide and substance abuse, therefore the early detection, diagnosis and aggressive treatment of these disorders is critical. It is important to assess for symptom clusters that define subtypes of depression like seasonality, atypical symptoms, and psychosis in order to develop an appropriate treatment plan. The most useful diagnostic tool for clinicians is the comprehensive diagnostic evaluation, including interviews with child, caregivers and other collateral sources. The psychiatric assessment of depressed children and adolescents should be conducted by a trained clinician who is aware of the developmental and cultural factors that may significantly impact a child's presentation. Lifetime mood charts and mood diaries can be used to document the longitudinal course of depression.

GENERAL TREATMENT OVERVIEW

Psychotherapy is considered appropriate for all children and adolescents diagnosed with depressive disorders. Antidepressant medications are helpful in some cases, especially when patients are not responding to an adequate trial of psychotherapy and/or display severe depression. Opinions among clinicians vary regarding treatment planning and treatment duration, however. It is agreed that **all** interventions should be adapted to the developmental stage of the child or adolescent and be provided in the least restrictive setting for the child. It is important for a treatment plan to match the intent of treatment to the severity of symptoms. Multiple sessions per week may be warranted during the acute treatment phase. The inclusion of caregivers in treatment is strongly recommended to facilitate the resolution of depressive symptoms. It is critical to foster an effective therapeutic rapport and alliance early in treatment so as to maintain and increase family involvement over the treatment course. A clinician should provide education to the child and all family members regarding the disorder and treatment to decrease misattributions made by children and caregivers (i.e. self-blame: "It's all my fault. I'm a bad parent." or blaming the child: "It's my kid's fault, he's just lazy or manipulative"). Psychoeducation enhances the team approach and overall compliance with treatment. Furthermore, parental mental health issues should be addressed. If warranted parents should be offered the appropriate treatment.

TREATMENT LITERATURE & RECOMMENDATIONS

There is controversy regarding whether psychotherapy, pharmacotherapy or a combination should be offered as first-line treatment for children and adolescents suffering from MDD. In fact, there is a debate regarding which psychotherapies or which parts of the psychotherapies are most efficacious. Several factors should be considered when choosing the initial acute therapy: (1) severity, (2) number of prior episodes, (3) chronicity, (4) subtype, (5) age of the patient, (6) contextual issues (family conflict, academic problems, exposure to negative life events), (7) compliance with treatment, (8) previous response to treatment and (9) the patient's and family's motivation for treatment (AACAP, 1998 p. 72). Other factors that also influence the selection and outcome of treatment is clinician availability, motivation, and expertise with a specific therapy.

Drawing from clinical experience and the few randomized treatment studies done with children and adolescents, psychotherapy has shown to be a helpful initial acute treatment for mild to moderate depression. Cognitive Behavioral Therapy (CBT) has been the most thoroughly studied, and other treatment modalities like psychodynamic psychotherapy, Interpersonal therapy (IPT) and family therapy have been proven effective and are often used clinically. The rationale for the use of CBT for depression is based on the idea that depressed patients have a distorted view of themselves, the world, and the future. CBT approaches teach children how to identify and counteract these inaccurate belief systems and misattributions. Continuation therapy is recommended when using CBT with children because clinical studies have shown a high rate of relapse upon follow-up. The IPT approach which focuses on interpersonal roles, role disputes and transitions and interpersonal difficulties, has been shown to be useful in the acute treatment phase with a low relapse rate. Psychodynamic therapy can help children better understand themselves, identify feelings, challenge maladaptive behavior patterns, improve communication with others, and gain coping skills. More research comparing these therapies is needed to better understand their effects. See reviews by Bemporad, (1994) and Birmaher et al., (1996b) for further discussion on psychotherapeutic techniques used with depressed children.

Antidepressant medication may be indicated for children and adolescents with depression of enough severity to interfere with academic and social functioning and the prevention of effective psychotherapy, and depression that fails to respond to an adequate trial of psychotherapy. Tricyclic Antidepressants (TCAs) and Selective Serotonin Reuptake Inhibitors (SSRIs) are the most commonly used medications with depressed children and have yielded conflicting results. The few studies that have been conducted on the use of these medications are open or methodologically flawed. Double-blind trials have shown no significant differences between TCAs and placebo. Overall, children and adolescents respond at a high rate to placebos.

Due to the positive results of SSRIs with adults with MDD, these medications are now commonly used to treat depressed children. To date, SSRIs are considered the 'antidepressants of choice' for children needing medication because they are relatively safe due to their very low lethality after overdose, have a good side effects profile, are easy to administer (once a day), and can be maintained on a long-term basis. Pharmacotherapy alone, is never considered a sufficient treatment. Pharmacotherapy combined with psychotherapy is recommended. A combined treatment approach not only stabilizes the patient's mood, but enhances the likelihood of alleviating depressive symptoms, improving self-esteem, enhancing coping skills and adaptive strategies, and improving relationships with family and peers (AACAP, 1998). The high degree of co-morbidity and psychosocial and academic problems caused by depression support the use of a mutimodal treatment approach.

Continuation therapy lasting for at least six months is recommended for all children and adolescents being treated for MDD. Continued treatment is supported by the high rate of relapse and recurrence of depression. After child patients have been asymptomatic for 6-12 months, the clinician must determine whether or not to continue therapy on a maintenance basis in order to prevent recurrence. Maintenance therapy is supported for patients with multiple or severe depressive episodes and those at high risk for recurrence. For example, patients who have a family history of Bipolar Disorder or recurrent depression, co-morbid psychiatric disorders, or are currently in a stressful and non-supportive living environments are potential candidates for maintenance therapy.

Crime-Specific Treatment for Depression

As with adult crime victims, trauma-focused treatment (e.g., addressing PTSD-symptoms and cognitions) produces improvement in childhood depressive symptoms. It is recommended that this be the first-line treatment. When symptoms do not abate or the child deteriorates or becomes suicidal, a shift to standard psychotherapeutic approaches is indicated.

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D. PSYCHOLOGICAL MANAGEMENT OF COMPLEX CASES

1. INTRODUCTION

In principle, it is prudent to follow empirically-validated treatment protocols. In practice, the lives and circumstances of clients are often far more complex than clients in research validation samples. Depending on the nature of factors producing complexity, different elements, an entirely different treatment plan might be required and the expected length of treatment may need to be increased. At times treatment for the crime-caused condition may need to be suspended until other conditions are well-managed or resolved.

Many different factors can contribute to the complexity of a case. Some examples include: multiple Axis I disorders, the presence of Axis II disorders, Axis III disorders as well as increased psychological stress and/or decreased social support. Some specific conditions include the presence of: chronic pain, traumatic brain injury, alcohol and other substance abuse, pre-crime psychopathology in Axis I as well as Axis II, higher than average psychosocial stressors and lower than average psychological support.

It is important that the clinician not only diagnose those conditions caused by a crime, but also the conditions exacerbated by the crime as well as conditions unrelated to the crime. As in all of the CVCP guidelines, the diagnoses should be multi-axial in accordance with the current *Diagnostic and Statistical Manual* published by the American Psychiatric Press.
To obtain CVCP benefits beyond the initial six sessions, the client must have a crime related psychiatric disorder as defined by the current edition of the *DSM* and must demonstrate capacity to benefit from the proposed treatment plan.

The CVCP is not required to authorize the treatment of co-morbid conditions that were not caused or exacerbated by the crime. However, if there are co-morbid conditions which pose a barrier to rehabilitation and recovery, and treatment is likely to promote recovery in a cost-effective manner, authorization for limited and focused treatment can be granted. Treatment of non-crime related conditions might not require the complete resolution of those conditions, but simply the management of them, so that they no longer pose a significant barrier to recovery from the crime related condition.

2. CO-MORBID FACTORS: ANGER

Anger is a common symptom in victims of trauma (Riggs, et al., 1992). Some studies have indicated that feelings of anger predict chroncity in post-traumatic stress disorder. There is also some evidence that preoccupation with anger interferes with the successful outcome of some types of psychotherapy (Foa, et al., 1995). Recent research has helped to clarify some of the conceptual confusion that has stymied attempts to define and delineate different types of dysfunctional anger reactions. Research has also demonstrated successful intervention protocols based on the cognitive-behavioral models, particularly the stress inoculation model (SIT). Finally, research has demonstrated that some popular treatment ideas and recommendations may not only fail to help resolve anger, but may actually aggravate anger problems.

PRINCIPLES OF DIAGNOSIS AND TREATMENT

Differential diagnosis is required to develop an appropriate treatment plan for anger problems. Jerry L. Deffenbacher (1996) commented that the *Diagnostic and Statistical Manual of Mental Disorders* does not recognize anger as constituting any discrete syndrome, but it is an important symptom in a variety of disorders. Some disorders may require or benefit from medications, some may respond to psychosocial procedures and environmental modifications alone.

- Anger associated with aggression and violence will first need to be safely contained.
- Psychiatric consultation for medication management should be considered when anger is intermittently explosive, part of a bipolar disorder or reflecting an organic mood disorder. Other conditions in which anger is present may also benefit from medications. In general, when in doubt, consult.
- With generalized anger, consider cognitive-behavioral models of intervention (Novaco, 1975).
- When aggression and violence are appropriately contained and anger is a significant factor in a marital or couples relationship, intervention models as developed by John Gottman and Neil Jacobson may have particular merit (Gottman, 1995, Jacobson, 1996).
- Expression oriented therapies appear to have no more than anecdotal support. A variety of clinical investigations suggest that expression or catharsis oriented treatments may reinforce subsequent episodes of anger and angry ruminations. With children, SIT and Aggression Replacement Therapy have shown significant success (Goldstein and Glick, 1987). Deblinger and Heflin (1996) have some useful recommendations for managing anger episodes in child victims of sexual abuse. Expression-oriented therapies may result in particularly hazardous outcomes in children (Feshbeck, 1956).

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3. CO-MORBID FACTORS: ANXIETY

INTRODUCTION

Anxiety can be a symptom of a number of mental disorders including other Axis II and Axis III disorders in the *DSM-IV* (1994). It is also a domain of Axis I disorders in the *DSM-IV* including: Agoraphobia, Panic Disorder without Agoraphobia, Panic Disorder with Agoraphobia, Agoraphobia without History of Panic Disorder, Specific Phobia, Social Phobia, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Anxiety Disorder Due to a General Medical Condition, Substance-Induced Anxiety Disorder, Anxiety Disorder Not Otherwise Specified, as well as the Posttraumatic and Acute Stress Disorders. In light of the complex nature of anxiety, this guideline intends to provide a general outline of how to proceed with clinical decision-making and care. It will also provide a selected bibliography of widely available publications for the professional audience as well as the general public including crime victims.

DIFFERENTIAL DIAGNOSIS

Anxiety that persists following a crime trauma, and the initial response to contain any crisis and provide education and support will need to be carefully evaluated. The clinician should evaluate the crime victim on all five axes of the *DSM-IV* using the principles of differential diagnosis. Such a procedure will help to assure that emotional symptoms caused by general medical disorders or substance use disorder are appropriately referred and treated. It will assure that symptoms of long-standing personality traits and personality disorders are not confused with acute reactions to trauma. Finally, it will assure that the specific nature of any Axis I anxiety pathology is sufficiently delineated so that appropriate treatment can be instituted.

TREATMENT

The American Psychological Association Task Force on Promotion and Dissemination of Psychological Procedures (1995), has identified several empirically validated treatment protocols for anxiety disorders. An update of the task force added additional empirically validated treatments. The following list reflects a compilation of both documents for those treatments passing empirical validation standards at the "well-established" and "probably efficacious" level:

Generalized Anxiety Disorder
Cognitive Behavior Therapy
Applied Relaxation

Simple Phobia
Exposure treatment
Guided mastery
Systematic desensitization

Agoraphobia
Exposure treatment

Panic Disorder with and without agoraphobia
Cognitive-behavior therapy
Applied Relaxation

Obsessive-Compulsive Disorder
Exposure and response-prevention treatment
Cognitive Therapy

Social Anxiety
Group cognitive therapy for social anxiety
Systematic desensitization

As indicated in other guidelines, these therapies have withstood the ordeal of empirical validation. Many other psychotherapeutic approaches may ultimately prove to be useful when they are submitted to appropriate empirical inquiry. The preceding review details psychological treatments only and doesn't consider the role of medications. There are a number of complex issues when using medication to treat anxiety-based disorders. In general consultation with a professional who has obtained specific training in the use of psychotropics, such as a psychiatrist or psychiatric ARNP or clinical psychiatric pharmacologist is best in order to identify symptom targets, appropriate medications (for instance,

medications classified as antidepressants may have a significant role in reducing intrusive ideation in PTSD and in managing Obsessive-Compulsive Disorder), as well as dosage and duration of treatment. In the section below, indication for medications and other psychiatric issues are reviewed.

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Kozak, M. J., & Foa, E. B. (1997). Mastery of obsessive-compulsive disorder: A cognitive behavioral approach, therapist guide. San Antonio, TX: The Psychology Corporation.

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4. CO-MORBID FACTORS: DRUG AND ALCOHOL ABUSE

There are several psychiatric disorders (Major Depression, Anxiety, Post-Traumatic Stress Disorder{PTSD} and Substance Abuse) that commonly occur in combination after a severe stress, including the stress of a crime. Substance abuse whether it precedes a crime, is exacerbated by crime victimization or begins as a consequence of crime victimization, can interfere with the resolution of the crime trauma. Recent studies have shown a particularly potent and maladaptive **combination of PTSD and Substance Abuse** in some crime victims. To understand the problem of substance abuse in crime victims we must begin by understanding how it is related to trauma and PTSD.

RELEVANT RESEARCH

Drug and alcohol abuse is strongly associated with PTSD. Stewart (1996) presents a critical review of over 300 clinical studies that demonstrate a highly positive correlation between trauma, PTSD and alcohol abuse.

- Alcohol and drug abuse is the most prevalent of all psychiatric disorders in the United States – 16% of the population has this disorder.
- Alcohol abusers report three times as much trauma as non-drinkers.
- Studies show a much stronger association with PTSD and alcohol abuse than with trauma exposure alone.
- PTSD signs and symptoms precede the development of alcohol abuse suggesting that PTSD somehow promotes abuse.
- Studies show a high degree of co-morbidity between PTSD and alcohol abuse – 40% to 70 % of adult subjects with PTSD will also have a diagnosis of alcohol abuse.

Longitudinal studies have shown that the PTSD disorder precedes drug and alcohol abuse. Drugs and alcohol may be abused as a maladaptive effort to self-medicate – to moderate the traumatic signs and symptoms of the trauma. Some individuals are incapable of coping with the intense fear and intrusions of flashbacks and nightmares which interfere with sleep; thus, use of drugs or alcohol as a tranquilizer or hypnotic is a short-term solution that may introduce a long-term problem. Abruptly discontinuing drugs or alcohol after several weeks of daily use will create a state of "rebound" in which the central nervous system is suddenly free of the inhibiting effects of whatever substance has been abused. That will begin an intense resurgence of the trauma responses that reinforces the need for continual abuse. When this cycle of abuse to control the mental distress of trauma becomes **persistent** and maladaptive, it is difficult to interrupt because it has now become the primary way that the victim can calm the mind from the mental effects of the crime.

MANAGEMENT AND INTERVENTION

Recently, the American Psychiatric Association published guidelines for the management of substance abuse problems based on comprehensive reviews of the current literature (APA, 1996). The guidelines acknowledge both the diversity of clinical conditions and the diversity of people who have substance abuse problems. While specific clients and problems vary, in general, treatment should be preceded by an assessment phase that is oriented both to differential diagnosis and the development of a treatment plan. The first step in treatment may be to help the person through the detoxification and withdrawal process. Depending on the substance abused, medications may play a therapeutic role. Treatment will need to include relapse prevention. Treatment providers may include trained professionals as well as volunteer support groups.

PRELIMINARY STRATEGIES FOR INTERVENTION

Crime victims, and those who provide support services to them, need to be aware of the very basic interactive effects of trauma, PTSD and Substance Abuse. Education will bring a recognition and identification of crime victims presenting with these disorders and their maladaptive combination.

There are well established treatment approaches for Substance Abuse; these interventions should be offered **before** the crime specific intervention is implemented. If the provider is unable to provide these services to the client, he/she should refer the client to the appropriate treatment services. In some cases, clinical service may require the simultaneous management of PTSD and Substance Abuse. While management of the Substance Abuse will take priority, the treatment of the underlying PTSD should begin when the victim has stabilized since untreated PTSD creates high risk for relapse of the Substance Abuse. There are no controlled studies of victims with these combined disorders to guide us in "staging" interventions specific for PTSD or Substance Abuse. In the absence of controlled studies, it would be appropriate to offer comprehensive and flexible clinical services for both, instead of an " absolute" protocol for only one.

CONTRAINDICATIONS

Some trauma specific interventions are contraindicated with clients who are currently abusing alcohol or drugs. Specifically, therapeutic interventions involving exposure components may be too stressful or overwhelming for crime victims who are currently abusing, as well as those who have recently achieved sobriety but are still at risk for relapse. Leading researchers in rape trauma and its treatment (Foa & Rothbaum, 1998), explain that a client abusing alcohol or drugs will most likely need to receive treatment for her substance abuse or dependence before she will be ready to deal with her assault. They strongly discourage using the prescribed trauma specific techniques with clients who have current substance abuse disorders and they recommend at least 90 days of sobriety before treating assault-related issues. Resick and Schnicke (1996) support this recommendation and do not advocate the implementation of Cognitive Processing Therapy (CPT) with someone who is currently abusing alcohol or drugs, nor for someone who is fragile in regard to sobriety. However, CPT can be implemented with clients who are comfortable with their sobriety and understand the importance of addressing strong emotions in therapy (Resick & Schnicke, 1996).

SUMMARY

In light of the current literature, substance abuse problems appear to take priority in treatment. Some issues may be dealt with concurrently by a different therapist than the one providing substance abuse treatment, while other issues such as PTSD may require a significant period of sobriety before therapy can be reasonably expected to be successful. Like any other mental health condition, substance abuse problems should be carefully diagnosed and assessed. A professional treatment plan should be developed on the basis of that diagnosis and assessment. The guidelines set by the American Psychiatric Association (1996) are based on a thoughtful and comprehensive review of the practice literature. While these guidelines were specifically developed to assist the practice of psychiatry, all clinicians no matter what their health-care credential's would be wisely guided by them.

Finally, it should be emphasized that this attention and service for psychiatric disorders with crime victims is viewed as crime related. PTSD and Substance Abuse are common responses to the trauma of crime and shall first be viewed as secondary effects of the horror and helplessness forced upon victims. Recovery for victims cannot begin unless our understanding and service is based upon this compassionate insight.

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RESOURCES

Children's Hospital in Boston, MA has developed a program (Advocacy for Women and Kids in Emergencies (AWAKE) that serves battered women who also have substance abuse problems. This program offers the traditional services of counseling, legal advocacy and emergency housing as well as drug and alcohol recovery services. AWAKE Children's Hospital, 300 Longwood Avenue, Boston, MA 02115. Phone: (617) 355-7979.

Office for the Prevention of Domestic Violence. (1998). Model domestic violence policy for countries. New York: New York State, Office for the Prevention of Domestic Violence. (New York State's Office for the Prevention of Domestic Violence has published an extensive strategy for the intra- and extra-agency management of substance abuse which might serve as a model document for a statewide agency.)

5. CO-MORBID CONDITIONS: SOMATOFORM DISORDERS

Persistent, often crippling physical complaints for which there is no demonstrable medical cause are a frequent and in some cases solitary consequence of traumatic events. Headaches, stomach and bowel problems, muscle and joint pain, fatigue and malaise, respiratory, cardiovascular, and genito-urinary complaints, and unexplained neurological problems are a few of the symptoms clusters grouped within the general diagnostic category of somatoform disorders. Women and children are more commonly affected than men. Some cultural groups tend to express their psychological distress more frequently in the form of the physical symptoms of somatoform disorders. Extensive medical evaluations and even surgery can complicate and delay appropriate treatment for this group of patients.

If a somatoform disorder is suspected, practitioners are encouraged to consider the following approach. The patient's symptoms should be acknowledged, and the patient reassured that her experience of physical suffering is believable and real. In the absence of a likely medical cause, symptoms may result from physical responses to the stress of her emotional injuries is introduced. As the stress is reduced, symptoms may improve. As treatment proceeds, the therapist remains interested and concerned about the course of the physical symptoms without letting them become the focus of treatment. Communications between the therapist and physician caring for the physical symptoms can also facilitate treatment.

E. CULTURAL ASSESSMENT AND CULTURALLY APPROPRIATE SERVICES

1. INTRODUCTION

Crime victims bring to treatment life experiences that are, in part, determined by racial, ethnic, cultural, and community backgrounds. Ethnicity and culture are powerful, and sometimes subtle, determinants of an individual's patterns of thinking, feeling, and acting. Social and cultural background can significantly affect the way an individual responds to victimization. Cultural influences and patterns also determine how and when to express distress, when and from whom to seek help, and the kind of help that will be accepted.

Victims of crime are not unique in their need for culturally-sensitive services. Clinicians should be sensitive and value the differences individuals bring to a helping relationship. It is important to understand the individual's perspective of their victimization and trauma. In addition, it is essential to understand the victims' healing and helping practices and beliefs. Community leaders, healers, and professional colleagues can be of great help, especially when they understand the victim's cultural background.

In order to support clinicians in providing sensitive and culturally relevant services to crime victims, the Washington State Crime Victims' Compensation Program (CVCP) will provide payment for consultations that focus on increasing a therapist's clinical understanding of the role and impact of culture and social group for an individual client. For more information, please refer to the *CVCP Mental Health Treatment Guideline on Crisis Response, Initial Assessment and Documentation Procedures* (1999), and to the "Consultation" section of the *Crime Victims' Compensation Program Mental Health Treatment Rules and Fees*, dated 1999 or later.

2. CULTURALLY DIVERSE POPULATIONS

Our professional understanding of human personality and functioning has traditionally been influenced by a white, middle-class norm. People may be different from that norm by ethnicity and/or race, and by social and/or class differences, such as people in poverty, sexual minorities, or individuals who are physically or developmentally challenged (Pinderhughes, 1995). Individual culture is not necessarily visible to the eye. To provide sensitive and appropriate clinical care, clinicians must acknowledge the legacy and presence of bigotry and prejudice in society.

Clinicians should understand that cultural minority clients are, at least, "bicultural," and may have more than two cultural influences. For example, it should not be assumed that a client's race or culture of origin is not a factor if they were raised in a different culture than their birth family. Another example, is that an individual raised in a heterosexual culture, who as an adult identifies as gay or lesbian, is influenced by experiences from both cultures. This multicultural status creates a unique set of social issues and the provider must be equipped to respond.

3. CULTURAL COMPETENCY IN TREATMENT

The word "culture" implies the integrated pattern of human behavior which includes actions, assumptions, values, reasoning, and communication of a racial, ethnic, religious, or social group. The word "competence" implies having the capacity to function in a particular way. Therefore, culturally competent services refer to systems, agencies, and practitioners who have the capacity to respond to the unique needs of populations whose cultures are different than that which might be called dominant or mainstream American.

Cultural competence is a set of congruent behaviors, attitudes, structures and policies which come together to work effectively in inter-cultural situations. That set of behaviors can be adopted and practiced by a solitary professional or an entire system of care. Ideally, cultural competence would be exercised by everyone in every association (National Indian Child Welfare Association, 1999).

It is impossible for a clinicians to fully understand the cultural background of every client. This guideline will outline some basic principles that can help therapists with clients from cultures different than their own. The perspectives and abilities that lead to cultural sensitivity and competence include the following.

- Clinicians must be curious and inquisitive. They must have the ability to respect, appreciate and accept the values, beliefs and practices of all clients, including those who are culturally different. They must perceive them as individuals not merely clients.
- Family, while defined in various ways, by different cultures, is most often the primary system of support, and the preferred point of intervention. Clinicians must be comfortable working in conjunction with these natural, informal supports, including helping networks within the clients' community (e.g., churches, healers, spiritual leaders, respected leaders).
- Barriers to services, including, but not limited to language, must be removed. For additional information, refer to the *CVCP Mental Health Treatment Guidelines on Utilization of Interpreters* and the guideline on *Meeting the Needs of Crime Victims with Disabilities*.
- It is important for clinicians to understand the specific values, beliefs and cultural practices of their clients in order to support client self-determination (Pinderhughes, 1995) and develop appropriate treatment plans. When treating victims of crime, it is necessary to understand the meaning of victimization to the client's culture, as well as the meaning of seeking help from a mental health professional.
- Clinicians must be comfortable with differences in others, and avoid responding with anxious or defensive behavior (Pinderhughes, 1995).
- Clinicians must think flexibly and recognize that one's own way of thinking and behaving is not the only or the right way to think and behave (Pinderhughes, 1995).
- Clinicians must know when to seek additional information and assistance from a colleague with expertise in a specific culture, whether the need is for limited or ongoing consultation. It is also vital that clinicians assess their own abilities and refer a client, when appropriate, to a more culturally competent colleague.
- Continuing education, aimed at increasing clinical competency with specific cultures, is an important means of expanding one's knowledge and expertise.

4. When and How to Access Cultural Assessments and Consultations

The decision to seek a cultural assessment or consultation is a subjective decision, and must be made by the treating clinician, for each client they serve. The decision to pursue a clinical consultation, or even to refer a client to a more culturally appropriate provider, should not be feared as an indication of clinical incompetence. Instead, it is an honest commitment to provide the best quality of care to the client.

Washington State is rich in cultural diversity within its community of agencies and mental health providers. This guideline should help you identify available sources for clinical assessments or consultations. The Washington State Crime Victims' Compensation Program does not specifically endorse the work of any agency or individual. But the following list of resources serves cultural minority clients, making the process of locating a cultural consultant easier for clinicians.

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RESOURCES

Abused and Deaf Women's Advocacy Services
2627 Eastlake Avenue East
Seattle, WA 98102-3213
(800) 833-6384 (tty)
(206) 726-0093

Northwest Network of Bisexual, Trans, and Lesbian Survivors of Abuse (formerly known as AABL)
PO Box 22869
Seattle, WA 98122
(206) 568-7777
(206) 517-9670 (tty)
www.AABL.org

Asian Counseling and Referral Service
720 8th Avenue South, Suite 200
Seattle, WA 98104
(206) 695-7600
Asian/Pacific Islanders

Asian Counseling
4301 S. Pine Street, Suite 405
Tacoma, WA 98409
(253) 471-0141
Cambodian, Korean, Vietnamese, Laotian, Filipino

Consejo Counseling and Referral Services
3808 South Angeline
Seattle, WA 98118
(206) 461-4880
After hours Crisis Clinic: (206) 461-3222
Hispanic and Latino

Seattle Counseling Services for Sexual Minorities
1820 East Pine Street
Seattle, WA 98122
(206) 323-1768
(800) 5B-PROUD

Seattle Indian Health Board
611 12th Avenue South
Seattle, WA 98144
(206) 324-9360
American Indian and Alaskan Native

Seattle Mental Health, Deaf and Hard of Hearing Program
1600 East Olive Street
Seattle, WA 98122
(206) 324-2400
Deaf or Hard of Hearing Community

The Refugee Women's Alliance
3004 South Alaska Street
Seattle, WA 98108
(206) 721-0243
Multi-ethnic center for refugee women

Therapeutic Health Services
5802 Rainier Avenue South
Seattle, WA 98118
(206) 723-1980
African American and Afro-Ethnic

Yakima Indian Health Center
401 Buster Road
Toppenish, WA 98448
(509) 865-2102
Mental Health Services for Native Americans only.

F. UTILIZATION OF INTERPRETERS

1. INTRODUCTION

People with limited English proficiency (LEP) and people who are deaf or hard of hearing face many barriers to health and mental health care. When communication barriers prevent providers from understanding clients, effective care is impossible. Not only may it be difficult to obtain the client's informed consent, but these barriers may also lead to improper diagnoses. Overcoming language barriers is critical to the well being of these clients. Consider hiring a bilingual provider or staff interpreter, or contracting with local language banks and community-based organizations who have staff fluent in various languages. Telephone translation services can provide interpreter services in over 140 different languages. A relay service for communication with patients who are deaf or hard of hearing is also available statewide (National Health Law Program, 1998).

2. DECIDING WHEN YOU NEED AN INTERPRETER

You must provide a trained interpreter whenever a client requests it, or when you believe that language or cultural differences may be preventing clear communication between you and the client. Clients may always refuse use of an interpreter.

Also, if the organization you work for receives federal funds of any kind, you are required to provide language assistance for limited-English-speakers. According to Title VI of the 1964 Civil Rights Act, no recipient of federal funding may run its program in such a way as to discriminate on the basis of race, color, or country of national origin. One method to ensure equal access to care is to work through trained interpreters.

3. HOW TO CHOOSE AN INTERPRETER

A certified interpreter is a trained professional who can speak at least two languages and works in a health or mental health setting to make possible communication among parties using different languages. The skills of a certified interpreter include cultural competency, awareness and respect, as well as mastery of medical/social service terminology (depending on specialization). This creates mutual trust and accurate communication leading to effective provisions of medical/social services (American Medical Interpreters and Translators Association, 1998).

The quality and availability of interpreter services will vary in different parts of the state, depending on available training and resources. In Washington State, certification is available for social service, medical and legal interpreters of Spanish, Russian, Vietnamese, Chinese, Korean, Cambodian and Laotian.

AT THE VERY LEAST, THE INTERPRETER SHOULD BE:

(Adapted from Cross Cultural Health Care Program, Working effectively with Interpreters in Health Care Services, 1998)

- **Fluent in both languages in question.** Language screening may be necessary to establish the degree of fluency.
- **Trained as an interpreter.** The fact that a person is bilingual does not make her or him an effective interpreter. Interpretation requires special skills that are acquired through training and experience. While training for interpreters will vary by region, some professional training is absolutely necessary. Certified interpreters must adhere to a professional code of ethics, including keeping all patient information confidential. Certified medical interpreters should also be familiar with medical terminology. It is useful for interpreters for crime victims to be familiar with issues and terms relating to victimization and mental health. Mistakes common to untrained interpreters include adding material, omitting material, changing messages, giving opinions, and not maintaining necessary professional boundaries.
- **Not a Community-Based Advocate.** An advocate's role is to support victims while the interpreters role is to remain as neutral as possible. When an advocate serves as interpreter a conflict of interest may occur that may ultimately be detrimental to the victim.
- **Not a family member.** Family members play a valid role in providing client support, however, they are not appropriate interpreters. In cases of family violence, using a family member for interpretation is not recommended as it may put the client at greater risk. Additionally, it can be unfair to ask a family member to take on the interpreter role when they may need to deal with their own response or feelings around a family member's health. It is difficult for a family member to remain neutral and strictly interpret the provider/client conversation, and victims may also be loath to discuss certain problems in front of a family member (confidentiality concerns become paramount). Family members are also likely to be unfamiliar with medical or clinical terminology. If absolutely necessary, a family member could be used for interviews where confidentiality and safety are not a concern, where nothing of a clinically sensitive nature will be discussed (such as setting up an appointment).
- **Never a child.** In addition to those concerns mentioned above, the use of children to interpret might create a power dynamic in the family where children are put in the position of having to take on a parental, adult role. Lack of vocabulary in both languages may be a problem when children interpret. In addition, children may be adversely effected by having to pass on bad news to a family member.
- **Appropriate fit with victim in terms of culture/ethnic/gender/age differences.** Be aware of ethnic, language (dialect/accent), and cultural differences between the client and interpreter and how those differences may shape interactions. Just because the client and interpreter share the same language does not mean they are culturally similar or that they will be able to communicate effectively. In some ethnic groups, women and girls prefer a female interpreter and some men and boys prefer a male. Some older clients may want an older interpreter.

In small communities it may be difficult at times to find an interpreter who isn't connected to the victim or perpetrator. In these cases discuss your concerns with the potential interpreter and refer to the interpreter code of ethics. Use a phone interpreter if you, the interpreter, or the client think it will be difficult for the interpreter to remain neutral.

4. ROLES OF THE MEDICAL/MENTAL HEALTH INTERPRETER

THE BASIC ROLE OF THE INTERPRETER IS:

- To facilitate understanding in communication between people who are speaking different languages.
- To dissolve the barriers that language differences create between people.
- To create conditions similar to those that would exist by two people sharing a common language.

SOME SPECIFIC ROLES OF THE TRAINED INTERPRETER ARE:

(Adapted from Cross-Cultural Health Care Program, Roles of the Medical Interpreter, 1998).

- **Conduit:** Rendering in one language accurately what has been said in the other, with no additions, no admissions, no editing or polishing.
- **Clarifier:** In this role the interpreter verbally explains or makes word pictures of terms that have no linguistic equivalent (or whose linguistic equivalent is not understood by the victim) and checks for understanding. The interpreter takes this role when he or she believes it necessary to facilitate understanding.
- **Culture Broker:** In this role, the interpreter provides a necessary cultural framework for understanding the message being interpreted. The interpreter takes this role when cultural differences are leading to a misunderstanding on the part of either the provider or the client.
- **Advocate:** Advocacy is an action an interpreter takes on behalf of the client outside the bounds of an interpreted interview. The advocate is concerned with the quality of care in addition to quality of communication. Interpreters appropriately become advocates when the needs of the clients are not being met due to a systematic barrier such as the complexity of the health/mental health care system or racism.

5. WORKING EFFECTIVELY WITH INTERPRETERS: BEFORE, DURING, AND AFTER THE SESSION

(Adapted from Graham, 1995).

BEFORE THE SESSION

- If possible hold a pre-visit conference with the interpreter- introduce yourself to the interpreter (this is especially important the **first** time you work with an interpreter.)
- Establish the interpreter's level of English skill and professional training, and request that the interpreter interprets everything into the first person (to avoid "he said, she said.")
- Establish the context and nature of the visit "Lourdes is a new client so I will be taking a history…"
- Determine if there are any time constraints on the interpreter.
- Ask the interpreter if he/she has any concerns that he/she wants to share before the visit.

DURING THE SESSION

- Introduce yourself to the family (if present) and the interpreter.
- Write down the interpreter's name and interview language on the progress note.
- Tell the interpreter where you want him or her to sit. Beside the provider or just in back of them is best because the client looks at both the provider and the interpreter.
- Direct questions to the client, not to the interpreter unless they are meant for the interpreter. If you are going to pause and ask the interpreter a question in English, tell the client that this is what you will be doing.
- Establish the style of interpretation. In general, speak at an even pace in relatively short segments; pause so the interpreter can interpret. Simultaneous interpretation may be useful for short statements like how to take medicines, but can often be confusing. Summary interpretation, where the provider or client makes long statements and the interpreter tries to summarize them can be used for simple problems and to explore sensitive areas but can lead to errors.
- Work to ensure that everything you say, everything the client says, and everything the family members (if present) say is interpreted.
- Do not hold the interpreter responsible for what the client says or doesn't say; the interpreter is the medium, not the source of the message.
- Be aware that many concepts you express have no linguistic or often even conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use; this may take longer than your original speech.
- Avoid highly idiomatic speech, complicated sentence structures, sentence fragments, changing an idea in mid-sentence, and asking multiple questions at the same time.
- Encourage the interpreter to ask questions and to alert you to potential cultural misunderstandings. Respect an interpreter's judgment regarding the cultural appropriateness and either ask for help in rephrasing questions or ask for help in eliciting information in a more appropriate way.
- Check your own assumptions. Avoid patronizing the client. A lack of English language skills is not a reflection of low cognitive functioning or lack of education.
- Acknowledge the interpreter as a professional in communication. Respect his or her role.
- Be patient. Providing care across a language barrier takes time. However, good rapport and clear communication will repay the time spent up front.
- Control the interview just as you would in a session where no interpreter is required. You have your job; the interpreter has his/hers.
- In closing the session make a plan for how to schedule the next appointment (ask the interpreter to help with this) and also a plan for how the client can change the appointment if needed (this can often be done through the interpreter or his/her agency.)

AFTER THE VISIT

- Do a post-visit conference with the interpreter outside the room if you have concerns about the interview. This can help determine if there are language problems (perhaps accents or dialects that are different,) or if the client has a mental illness that presents a barrier to communication.

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RESOURCES

American Cultural Exchange: (206) 281-8200
Translation and Interpreter services in over 80 languages

***AT&T Language Line Services:** (800) 752-6096 (to apply); (800) 528-5888 General Public (Fee)
Phone Interpreters: Translation in over 140 languages, available 24 hours daily

Central Washington Service Center for the Deaf and Hard of Hearing: (509) 452-9823 (v/tty)

Chinese Information and Service Center: (206) 624-5633
Translation Services in five major Chinese dialects (Mandarin, Cantonese, Toishanese, Taiwanese, and Fujianese) and Cambodian

Community Service Center for the Deaf and Hard of Hearing: (206) 322-4996 (v/tty);
(206) 322-5551 (Interpreter Referral)
Programs for those who are deaf, deaf-blind, or hard-of-hearing. Services can be provided in American Sign Language or other accessible formats. Services are provided in King, Clallam, Island, Jefferson, San Juan, Skagit, Snohomish, and Whatcom counties, and Bainbridge Island.

Community Service Center for the Deaf and Hard of Hearing: (206) 322-4996 (v/tty)

Eastern Washington Service Center for the Deaf and Hard of Hearing: (509) 328-9220 (voice);
(509) 328-8965 (tty)

Eastside Multi-Ethnic Center: (425)643-2221
Staff available to translate written material in Vietnamese, Chinese, Laotion, Hmong, Russian, Bosnian, Spanish

Filipino Youth Activities, Inc.: (206) 461-4870
Tagalog, Visayan, and Ilocano translation

Horn of Africa: (206) 760-0550
Provides interpreter services on a contract basis to non-profit agencies. Available languages include Amharic, Tigrinya, Somali, and Oromo.

Korean Community Counseling Center: (206) 784-5691
Korean translators and interpreters available

Office of Deaf and Hard of Hearing Services: (360) 753-0703 (voice); (360) 753-0699 (tty)

Refugee Federation Service Center: (253) 852-5150 (Kent); (206) 725-9181 (Seattle);
(206) 762-4894 (White Center)
Translation and interpretation services for Laotain, Cambodian and Vietnamese refugees in King County

Samoan Pacific Islanders Association: (206) 938-2334
Interpretation in languages including Samoan and Tongan

Southwest Washington Service Center for the Deaf and Hard of Hearing: (360) 695-3364 (voice);
(360) 695-9720 (tty)

***Washington State Telecommunications Relay Service:** (800) 833-6384 (Voice)
This service links deaf and hard of hearing people via the telephone. To use this service dial the number above and give the agent the number you would like to call. He or she will stay on the line to relay the conversation. You can talk directly with the person you are calling. All calls and information are confidential. This is a 24 hour service provided at no cost to callers (long distance calls will be billed accordingly.)

*** indicates statewide access**

G. MEETING THE NEEDS OF CRIME VICTIMS WITH DISABILITIES

1. INTRODUCTION

According to the U.S. Department of Justice, there are approximately 43 million individuals with disabilities in the United States (Rubin, 1993). There are many issues facing crime victims who are disabled. For those who are not disabled before a crime, trauma is exacerbated when they become disabled as a result of their victimization. The Crime Victims with Disabilities Awareness Act (1998) states that individuals with disabilities are at greater risk of being victims of violence.

The risk of being physically or sexually assaulted for adults with developmental disabilities is estimated 4 to 10 times higher than it is for other adults (Sobsey, 1994). Increased vulnerability can be partially attributed to communication difficulties, mobility limitations, or dependence on caregivers.

In many situations with both disabled and non-disabled persons, the victim's family or caregiver may be the perpetrator of the assaults, abuse or neglect. Persons with severe disabilities are particularly at risk to such victimization. Victims who are dependent on their abuser are even more reluctant than others to report the victimization, due to fear of retaliation. Persons with disabilities are also at greater risk of repeat victimization when compared to non-disabled victims of crime.

Non-institutionalized Americans with disabilities often lack assistance in the aftermath of criminal victimization, and most will not seek assistance from either legal or treatment services. Thus, they may experience increased physical or social isolation as a result of their victimization.

Developmentally disabled persons often have a strong, involved network of service providers and caregivers e.g., family, physical and occupational therapists, and case managers. It is important for clinicians to collaborate and consult with existing providers, to obtain an understanding of the client's disability and needs and any existing treatment that is occurring, as it might be relevant to the mental health treatment being provided. Additionally, these individuals can take an active role in the treatment process, e.g., helping to implement treatment goals. When necessary, clinicians should refer clients for a full assessment of cognitive and physical functioning. This can often be coordinated with existing caregivers.

2. UNDERSTANDING DISABILITY DOMAINS

When working with a disabled person it is helpful to develop an understanding about the client's specific disability. Treatment should be oriented to the client's cognitive and physical abilities.

Baladerian (1998) describes disabilities as occurring in six major domains:

1. **INTELLIGENCE** disabilities related to intelligence include amnesia, mental retardation, learning disabilities, organic brain syndrome, other brain damage or developmental impairment.
2. **COMMUNICATION** disabilities include aphasia, autism, cleft palate, speech production impairment and language processing impairment.
3. **SENSORY** disabilities include deafness, hearing impairment, blindness, visual impairment, deaf and blind, mute and absent pain awareness.
4. **MOTOR** disabilities include Cerebral Palsy, Muscular Dystrophy, and other Central Nervous System impairments.
5. **SOCIAL** disabilities include Autism, Schizophrenia, and Personality Disorders.
6. **PSYCHIATRIC** disabilities include personality disorders, thinking disorders such as psychosis, clinical problems including depression, anxiety, and dissociative disorders.

3. INSTITUTIONAL BARRIERS TO OBTAINING ASSISTANCE

Persons with disabilities have historically been perceived as "suffering" and as the deserving recipients of "charity." Until the Americans with Disabilities Act (ADA, 1990), paternalism and charity were often the substitute for civil rights protection for persons with disabilities. People with disabilities continue to be perceived as lacking the ability to make competent choices in all spheres of their lives. Many citizens avoid persons with disabilities for fear that the stigma of a disability will be contagious. Deviations from the physical and sensory norms of self-sufficiency in all spheres and mobility frighten many in the "able-bodied majority" who provide the definition of "normal." Baladerian (1998) explains that until the recent inclusion movement, the life experience of persons with disabilities has consisted of segregation from not only the general community, but also generic programs including schools, transportation, health/mental health centers, abuse-response agencies and rape treatment centers. General information about the community in which they live is not learned through "osmosis" as it is with the non-disabled population. As a result, information about the services around them is unavailable.

Few victim assistance programs are designed to meet the needs of individuals with disabilities (National Institute of Justice, 1998). Services for victims with disabilities were largely overlooked on the national level until the 1990 passage of the Americans with Disabilities Act (ADA). The ADA required states and organizations receiving public funding to make their services accessible to all persons. Since then there have been several efforts to provide information to state and local criminal justice agencies and victim assistance programs on achieving ADA compliance (National Institute on Justice, 1998). However, mental health treatment programs with staff whom are knowledgeable about disability issues are limited. This includes a lack of inpatient and residential treatment programs that are equipped to accommodate and understand the needs of persons with disabilities.

Some of the issues confronting crime victims with disabilities are similar to those affecting all crime victims. These include: underreporting of crimes, the perceived lack of credibility of the crime victim, corresponding lack of responsiveness by law enforcement and/or prosecutors. Additionally, people with disabilities and non-disabled victims may lack the strength, stamina, and resources to interact with the criminal justice system or available resources.

Issues of credibility are an area of concern, especially among persons with speech impairments and mental or cognitive disabilities. As an example, a telephone intake worker may attribute slurred speech as someone on drugs or alcohol, and not consider the possibility of a speech impairment or cerebral palsy.

Some slow learners or persons with emotional issues might not track a conversation on the phone very well and therefore tend to be dismissed by phone workers, law enforcement officials, court officials and emergency personnel. Consent can also be a difficult area as well. Individuals with cognitive disabilities are often agreeable by nature and may be quick to provide their consent. In addition, disabled persons have frequently been taught by service providers to be compliant. This could result in the provision of consent, without awareness of the implications. In sexual abuse cases, determining the victim's understanding of consent can be a complex and challenging process.

4. TREATMENT ISSUES

Crime victimization may significantly alter the lives of victims with and without disabilities. Appropriate support and treatment can help victims reconstruct their life. This section will make general treatment recommendations for serving victims with disabilities. The Crime Victims Compensation Program (CVCP, 1999) guideline on initial response, assessment and documentation procedures and the guideline on advocacy services also provide useful information about providing assistance to crime victims, as do the other CVCP treatment guidelines dealing with clinical conditions known to affect crime victims.

Examples of Appropriate Terminology (Based on Baladerian, 1998)

Inappropriate Language	Preferred Language
handicapped, the disabled, crippled	person with a disability
the wheelchair or wheelchair bound	wheelchair user
mentally retarded	slow learner

Preparation for Working with an Individual with a Disability (Based on Baladerian, 1998)

A. When preparing for working with an individual with a disability:
    1. Focus on how you are alike.
    2. Consider the concept of TAB (we are all temporarily able bodied).
    3. Employ therapeutic empathy.

B. Psychological Aspects of Treatment:
    1. Prepare the client for the interview.
    2. Focus upon knowledge as power for the client.
    3. Maintain awareness of the client's possible limited reading ability.
    4. Be aware of the client's need to be accompanied, or pressure on the victim to be accompanied.
    5. Treat the client with dignity and respect, irrespective of their cognitive or physical impairment.

C. Identify Practical Aspects of Treatment:

1. Assess the need for an interpreter (due to speech production differences, use of assistive technology, facilitated communication, sign language, language processing impairments).
2. Become familiar with the ethics of practice while using an interpreter, for example, know how to access and hire an interpreter ***(please refer to the CVCP guideline on utilization of interpreters, 1999)***.
3. If appropriate with deaf clients, utilize a note pad and pen to communicate. Also inquire about whether the client uses any assistive hearing devices.
4. If the client takes medication, make sure it has been administered prior to the interview if necessary.
5. Prior to the session know if the client has a conservator who makes decisions regarding care and removes or affects your legal authority to conduct the interview. If your client is determined to be incompetent, or is a dependent adult (e.g., has a protective payee or guardian), make sure you are familiar with the laws regarding these issues.
6. Consider the applicability of:
    a. Evaluating the potential physical barriers associated with accessing the building, e.g., entering the building, getting to the office, using the bathroom, public telephone and drinking fountain.
    b. The accessibility and sensitivity of the interview setting. Ensure sufficient room to maneuver for those using wheelchairs, scooters and other assistive devices, and adequate space for all persons present.
    c. Reducing if not eliminating noise and visual stimuli that could be distracting.
    d. The accessibility of literature:
        i. Are materials easy to read e.g., large print, simple language (third grade reading level is recommended), and in the language of the client?
        ii. Are brochures free of staples?
        iii. Do brochures lay flat when open?
        iv. Can literature be translated into Braille or put on tape if necessary?
        v. Are consents available on tape as well as in written form(s)?

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RESOURCES

National Council on Independent Living
2111 Wilson Blvd.
Suite 405
Arlington, VA 22201
(703) 525-3406 (voice)
(703) 525-3407 (TTY)

Americans with Disabilities Act Hotline
U.S. Department of Justice
(800) 514-0301 (voice)
(800) 514-0383 (tdd)

Disability and Business Technical Assistance Centers (DBTACS)
(800) 949-4232 (voice/tdd)

H. ADVOCACY SERVICES

1. HISTORY OF ADVOCACY

Residents of Washington benefit from the rich history of victim services and system response to victims. Some of the earliest services available, nationally, for victims of sexual assault and domestic violence were in Washington. Some of the earliest efforts to create special assault units within law enforcement and prosecution agencies began in Washington communities. Washington laws are some of the most progressive and inclusive in the nation and are often used as models for other states. Likewise, Washington has been a leader in research and the development of treatment knowledge and practices for victims of crime. Many programs, often supported by public funds, are cited as model programs for other states.

Much of this history is the product of advocacy. Advocacy operates from the awareness that those victimized are responding normally to an abnormal event – crime victimization. Every individual responds differently to each incidence of victimization, depending on a myriad of circumstances and life experiences. Many, perhaps most, rely on their own resources to recover from the impact of victimization. Another large number are assisted by and recovers through the services provided by community-based or system-based advocates. It is a much smaller group, then, that seeks and receives therapy. For many victims of crime, it is the partnership of services between advocacy and therapy that most effectively and quickly results in recovery from the impact of crime.

EMPOWERMENT

Advocacy is based on the philosophical foundation of empowerment. The experience of victimization results in loss of control and a feeling of helplessness. Regardless of the specific crime and other individual factors, this loss of control of one's life and consequent helplessness is nearly a universal crime victim experience. To respond to victims in a manner that empowers, then, requires the fundamental belief that people are capable and know what they need. Empowerment, amidst the throes of the crisis and chaos reaction to victimization, may seem incongruent. That is why advocacy is so vitally important.

CHOICE

An advocate will intervene and provide services in such a way as to immediately begin to restore control and self-direction to the victim. The initial way an advocate empowers a victim is in the realm of choice. Whenever possible, an advocate will provide information upon which the victim can make an informed choice. An advocate is totally invested in carrying out the choices and assuring there are choices for the victim. Advocates and other system staff may not like the choices or think those choices are in the best interest of the victim – but advocacy is based on the right and power of the victim to make those choices for themselves.

VICTIM RIGHTS

The next concept instrumental to advocacy is the protection of the statutory and human rights of the victim. From the immediate response to a crime through medical services, law enforcement investigation, criminal case proceedings, sentencing, offender confinement and release, and treatment services, victims have statutory rights. Those rights focus primarily on safety, protection, and participation of the victim through the various processes that come into play after a crime. There are some differences in how these services look or are delivered between community-based and system advocates.

2. ADVOCACY SERVICES

Typical services provided by advocates include crisis intervention, information, referral, support, accompaniment, and assistance. Victims have the right to have an advocate present, for instance, during sexual assault medical exams, and during all hearings, interviews, and processes involved in a criminal prosecution. An advocate typically explains the procedures or process, informs the victim why some questions are asked or what purpose some procedures serve in a particular phase of a case. Advocates often interface with child protective services, schools, emergency services, employers, and faith communities on behalf of a victim, in order to assure or expedite the needs and wishes of a victim.

SYSTEM-BASED ADVOCACY

Advocates in system-based programs, usually within prosecuting attorneys' offices but sometimes part of law enforcement agencies, typically have easy access to information about the status of cases in the justice system. They are in a good position to assist victims in getting access to those in the system who will be making decisions about their cases – law enforcement officers, prosecutors, judges, and corrections officers. They can assist and support victims in such practical matters as participating in the investigation and the judicial process, getting property returned, and obtaining restitution or crime victim compensation. Because of their position within criminal justice agencies, they can often be very effective in representing the needs, concerns, or perspectives of crime victims to others within the justice system, both in specific cases and in the development of policy.

COMMUNITY-BASED ADVOCACY

Community-based organizations that serve and advocate for victims of crime usually specialize in serving victims of particular kinds of crimes, and tailor their services to meet the needs of their client populations. They are often the primary sources in their communities for such services as emergency shelter for victims of domestic violence, counseling for victims of child abuse, or support groups for rape victims or family members of homicide victims. As a principal focus of their services, these agencies advocate for their clients, both in specific cases and as they seek changes in systems to make them more responsive to their clients' needs. As independent agencies outside the criminal justice system, they are free to advocate vigorously on behalf of their clients, even when those clients' interests or choices conflict with those of agencies within the system. These community-based programs generally adhere to a philosophy in which empowering the victim, making the victim's choices and safety the paramount consideration, guides the provision of all services.

SYSTEM AND COMMUNITY-BASED ADVOCACY IS COMPLIMENTARY

Both types of victim advocacy service programs offer specific strengths in their ability to serve victims of crime. From a victim's standpoint, it is advantageous to have access to both, especially in cases where there is a criminal investigation or prosecution. For access to exist in a community, of course, active, viable victim service programs must be in place both within and outside of the justice system. However, such access is ideally secured through close, well-defined partnerships among system-based and independent, community-based victim service programs. Such partnerships increase the probability that crime victims will be regularly linked with the services they need at the time they need them, and decrease the likelihood of "falling between the cracks" in community resources. These arrangements also leave the agencies involved free to focus their efforts on the things they do best, secure in the confidence that the other partners will fulfill their roles as well.

3. A TREATMENT PARTNERSHIP BETWEEN ADVOCACY AND THERAPY

The services of advocacy can compliment services of therapy. Advocates are available on a 24-hour and immediate basis, can offer skills and techniques to handle nightmares, flashbacks, until therapy can establish new coping and recovery skills.

Advocates contribute to therapy by normalizing the victim's response to victimization and the consequent need for therapy. They approach crime victims from the philosophical position that they are responding normally to an abnormal event and that there are specialized services that can help them recover. Thus, much of the stigma, fear of diagnosis, and reluctance to seek therapy can be alleviated. Advocates can offer ongoing, supportive services to family members and the primary victim.

Advocates can help victims assess their needs and provide information about the process and potential benefits of therapy. Advocates can provide information to victims on how to choose and assess a therapist they are considering seeing. Advocates should know the therapists in their community and know the background, training, and specialty areas of each therapist, in order to make an informed and appropriate referral.

THERAPISTS AS ADVOCATES

Victim advocacy, as a service, is not limited to those who identify professionally as victim advocates. Others advocate for those they serve, including therapists. Advocacy by a therapist may be on behalf of an individual victim, in a particular circumstance (e.g., providing perspective to Child Protective Services on the therapeutic impact of moving the child to another foster home or coaching a teacher on how to appropriately respond to the behavior of a child who has been victimized). Another venue of therapists advocating is public policy or systems advocacy (e.g., contacts with insurance companies to secure additional treatment sessions, providing testimony at hearings on the impact of a proposed law, sitting on task forces and committees of public agencies that develop policy regarding how services will be delivered to victims of crime).

Thus, a community approach that values and supports the entire continuum of services needed by victims of crime is the ideal. Strong working partnerships between system and community-based advocates and the therapy community are an integral part of fulfilling the continuum of services in a community.

4. WASHINGTON COMMUNITIES

Victims of crime in the State of Washington can receive services in their own communities from a number of different sources. Though the availability and specific configuration of the services varies from one community to the next, there are certain types of victim service agencies that can be found in most areas of the state.

Every community in Washington is within the service area of an identified sexual assault and/or domestic violence shelter program. In some counties, those agencies are either sexual assault or domestic violence. In other counties, a single agency serves both victim populations. Every domestic violence shelter program must meet statutory requirements regarding training, supervision and service delivery. In addition, there are extensive WACs that govern the health and safety of shelter buildings. Those program standards are funded and administered by the Department of Social and Health Services. A community sexual assault program is so designated and funded by the Office of Crime Victims Advocacy, administered within the Department of Community, Trade and Economic Development. To attain this designation, an agency must demonstrate adherence to comprehensive management, training, supervision, infrastructure, and service delivery standards.

Most county prosecutor's offices in the state have victim/witness programs. Advocates in these programs assist victims during their involvement in the criminal justice process, and also link them with other sources of help in the community. They often assist victims in completing CVCP applications, obtaining needed supporting documentation for their claims, and finding mental health service providers that can accept CVCP reimbursement. These system-based advocates serve victims of all types of crime.

In addition to these local agencies, there are two organizations that advocate on a statewide basis for sexual assault and domestic violence services, funding, legislation, and systemic improvement:

- The Washington Coalition of Sexual Assault Programs can be reached at (800) 775-8013 or by email at wcsap@wcsap.org.
- The Washington State Domestic Violence Hotline can be reached at (800) 562-6025 v/tty (24 hours).

Finally, Washington's commitment to victims of crime was demonstrated through legislative action in 1990, when the Office of Crime Victims Advocacy (OCVA) was created as a voice within state government to speak on behalf of victims of crime and their needs. OCVA provides advocacy services directly to individual victims, as well as providing systems advocacy on behalf of all victims of crime. In addition, OCVA administers grant funds to community-based and local government agencies to provide direct services and prevention efforts in the areas of sexual assault, domestic violence, and youth violence. OCVA also maintains a statewide database of services for victims of crime.

- For additional information about OCVA or to receive the newsletter, training or funding notices, you can call (800) 822-1067 or email at ocva@cted.wa.gov.

APPENDIX A:
PERSONALIZED SAFETY PLAN FOR DOMESTIC VIOLENCE

Adapted from:

Barbara Hart and Jane Stuehling. (1992). Pennsylvania Coalition Against Domestic Violence. Reprinted with permission from the *Washington State Domestic Violence Team Training Manual*, sponsored by the Washington State Criminal Justice Training Commission, produced by the Washington State Coalition Against Domestic Violence. Lacey, WA (360) 407-0756

Name: _____
Date: _____
Review dates: _____

The following steps represent my plan for increasing my safety and preparing in advance for the possibility of further violence. Although I do not have control over my partner's violence, I do have a choice about how to respond to him/her and how to best get myself and my children to safety.

Safety during a violent incident. Women cannot always avoid violent incidents. In order to increase safety, battered women may use a variety of strategies.

I can use some or all of the following strategies:

- If I decide to leave, I will _____. (Practice how to get out safely. What doors, windows, elevators, stairwells or fire escapes would you use?)
- I can keep my purse and car keys ready and put them (place)_____ in order to leave quickly.
- I can tell _____ about the violence and request they call the police if they hear suspicious noises coming from my house.
- I can also tell_____ about the violence and request they call the police if they hear suspicious noises coming from my house.
- I can teach my children how to use the telephone to contact the police and the fire department.
- I will use _____ as my code word with my children or my friends so they can call for help.

If I have to leave my home, I will go _____
(Decide this even if you don't think there will be a next time.)

If I cannot go to the location above, then I can go to _____or _____.

I can also teach some of these strategies to some/all of my children.

When I expect we are going to have an argument, I will try to move to a space that is lowest risk, such as _____ (Try to avoid arguments in the bathroom, garage, kitchen, near weapons or in rooms without access to an outside door.)

I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we are out of danger.

Safety when preparing to leave. Battered women frequently leave the residence they share with the battering partner. Leaving must be done with a careful plan in order to increase safety. Batterers often strike back when they believe that a battered woman is leaving a relationship.

I can use some or all of the following safety strategies:

- I will leave money and an extra set of keys with _____ so I can leave quickly.
- I will keep copies of important documents or keys at _____
- I will open a savings by _____ to increase my independence.
- Other things I can do to increase my independence include:
  _____
  _____
  _____
  _____

The domestic violence program's hotline number is _____

I can seek shelter by calling this hotline.

I can keep change for phone calls on me at all times. I understand that if I use my telephone credit card, the following month the telephone bill will tell my batterer those numbers that I called after I left. To keep my telephone communications confidential, I must either use coins or I might get a friend to permit me to use their telephone credit card for a limited time when I first leave.

I will check with _____ and _____ to see who would be able to let me stay with them or lend me some money.

I can leave extra clothes with _____.

I will sit down and review my safety plan every _____ in order to plan the safest way to leave the residence. _____ (domestic violence advocate or friend) has agreed to help me review this plan.

I will rehearse my escape plan and, as appropriate, practice it with my children.

Safety in my own residence. There are many things that a woman can do to increase her safety in her own residence. It may be impossible to do everything at once, but safety measures can be added step by step.

Safety measures I can use include:

- I can change the locks on my doors and windows as soon as possible.
- I can replace wooden doors with steel/metal doors.
- I can install security systems including additional locks, window bars, poles to wedge against doors, an electronic system, etc.
- I can purchase rope ladders to be used for escape from second floor windows.
- I can install smoke detectors and purchase fire extinguishers for each floor in my house/apartment.
- I can install an outside lighting system that lights up when a person is coming close to my house.
- I will teach my children how to use the telephone to make a collect call to me and to _____ (friend/minister/other) in the event that my partner takes the children.
- I will tell people who take care of my children which people have permission to pick up my children and that my partner is not permitted to do so. The people I will inform about pick-up permission include:

  _____ (school),
  _____ (day care staff),
  _____(babysitter),
  _____ (Sunday school teacher),
  _____ (teacher),
  and_____ (others).

- I can inform_____(neighbor), _____(pastor), and _____ (friend) that my partner no longer resides with me and they should call the police if he is observed near my residence.

Safety with a protection order. Many batterers obey protection orders, but one can never be sure which violent partner will obey and which will violate protection orders. I recognize that I may need the police and the courts to enforce my protection order.

The following are some steps that I can take to help the enforcement of my protection order:

A. I will keep my protection order _____(location). (Always keep it on or near your person. If you change purses, that's the first thing that should go in.)

B. I will give my protection order to police departments in the community where I work, in those communities where I usually visit family or friends, and in the community where I live.

C. There should be a county registry of protection orders that all police departments can call to confirm a protection order. I can check to make sure that my order is in the registry. The telephone number for the county registry of protection orders is: _____.

D. For further safety, if I often visit other counties in Washington, I might file my protection order with the court in those counties. I will register my protection order in the following counties _____.

I can call the local domestic violence program if I am not sure about A, B, C, or D. above or if I have some problem with my protection order.

I will inform my employer, my minister, my closest friend and _____ and _____ that I have a protection order in effect.

If my partner destroys my protection order, I can get another copy from the courthouse by going to _____.

If my partner violates the protection order, I can call the police and report a violation, contact my attorney, call my advocate, and/or advise the court of the violation.

If the police do not help, I can contact my advocate or attorney and will file a complaint with the chief of the police department.

I can also file a private criminal complaint with the district justice in the jurisdiction where the violation occurred or with the district attorney. I can charge my battering partner with a violation of the protection order and all the crimes that he commits in violating the order. I can call the domestic violence advocate to help me with this.

Safety on the job and in public. Each battered woman must decide if and when she will tell that her partner has battered her and that she may be at continued risk. Friends, family and co-workers can help to protect women. Each woman should consider carefully which people to invite to secure her safety.

I might do any or all of the following:

- I can inform my boss, the security supervisor and _____ at work of my situation.
- I can ask _____ to help screen my telephone calls at work.
- When leaving work, I can _____.
  When driving home if problems occur, I can _____.
- If I use public transit, I can _____.
- I can use different grocery stores and shopping malls to conduct my business and shop at hours that are different than those when residing with my battering partner.
- I can use a different bank and take care of my banking at hours different from those I used when residing with my battering partner.
- I can also _____.

Safety and drug or alcohol use. Most people in this culture use alcohol. Many use mood-altering drugs. Much of this use is legal and some is not. The legal outcomes of using illegal drugs can be very hard on a battered woman, may hurt her relationship with her children and put her at a disadvantage in other legal actions with her battering partner. Therefore, women should carefully consider the potential cost of the use of illegal drugs. But beyond this, the use of any alcohol or other drugs can reduce a woman's awareness and ability to act quickly to protect herself from her battering partner. Furthermore, the use of alcohol or other drugs by the batterer may give him/her an excuse to use violence Therefore, in the context of drug or alcohol use, a woman needs to make specific safety plans.

If drug or alcohol use has occurred in my relationship with the battering partner, I can enhance my safety by some or all of the following:

- If I am going to use, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety.
- I can also _____.
- If my partner is using, I can _____.
- I might also _____.
- To safeguard my children, I might _____and _____.

Safety and my emotional health. The experience of being battered and verbally degraded by a partner is usually exhausting and emotionally draining. The process of building a new life for myself takes much courage and incredible energy.

To conserve my emotional energy and resources and to avoid hard emotional times, I can do some of the following:

- If I feel down and ready to return to a potentially abusive situation, I can_____
- _____. When I have to communicate with my partner in person or by telephone, I can _____
- _____ _____.
- I can try to use "I can…" statements with myself and to be assertive with others.
- I can tell myself - "_____" – whenever I feel others are trying to control or abuse me.
- I can read _____ to help me feel stronger.
- I can call _____ and_____ as other resources to be of support to me.
- Other things I can do to help me feel stronger are: _____ _____ _____.
- I can attend workshops and support groups at the domestic violence program or _____ or _____ to gain support and strengthen my relationships with other people.

Items to take when leaving. When women leave partners, it is important to take certain items with them. Beyond this, women sometimes give an extra copy of papers and an extra set of clothing to a friend just in case they have to leave quickly.

It is important to take the items on the following list. If there is time, some items might be taken or stored outside the home.

These items might best be placed in one location, so that if we have to leave in a hurry, I can grab them easily.

When I leave, I should take:

Identification for myself
Children's birth certificates
My birth certificate
Social Security cards
School and vaccination records
Money
Checkbook, ATM (Automatic Teller Machine) card
Credit cards
Keys - house/car/office
Drivers license and registration
Medications
Welfare identification
Work permits
Green Card
Passport(s)
Divorce papers
Medical records - for all family members
Lease/rental agreement, house deed, mortgage payment book
Bank books
Insurance papers
Small salable objects
Address book
Pictures
Jewelry
Children's favorite toys/or blankets
Items of special sentimental value

Phone numbers I need to know:

Police department – home _____
Police department – school _____
Police department – work _____
Battered women's program _____
County registry of protection orders_____
Work number _____
Supervisor's home number _____
Minister _____
Other _____

APPENDIX B:
BIBLIOGRAPHY OF GENERAL READING

The following list is only a brief summary of available literature, please refer to individual guidelines for topic specific recommendations. Additionally, contact the Washington State Coalition Against Domestic Violence on Washington Coalition of Sexual Assault Programs (see Appendix C on page 135).

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APPENDIX C:
RESOURCE LIST

STATEWIDE RESOURCES

Washington State Domestic Violence Hotline: (880) 562-6025 v/tty ***(24 hours)***

Washington Coalition of Sexual Assault Programs (WCSAP) 360 754-7583
Directory of Sexual Assault Services

Washington State Coalition Against Domestic Violence (WSCADV) 360 407-0756
Directory of Domestic Violence Services

APPENDIX D

CRIME VICTIMS' MENTAL HEALTH TREATMENT GUIDELINES TASK FORCE PARTICIPANT INFORMATION

MENTAL HEALTH PROVIDERS

LUCY BERLINER, MSW

Lucy Berliner served as co-chair of the Crime Victims' Mental Health Treatment Guidelines Task Force. She is currently Research Director at Harborview Center for Sexual Assault and Traumatic Stress, and a Clinical Associate Professor at the University of Washington, School of Social Work and Department of Psychiatry and Behavioral Sciences.

Ms. Berliner provides clinical treatment to child and adult trauma victims and conducts research on the impact of trauma and the effectiveness of clinical and societal interventions. Additionally, she is a participant in local and national social policy initiatives to promote the interests of trauma victims.

Ms. Berliner serves on the following editorial boards of The Journal of Interpersonal Violence, Child Abuse and Neglect, Child Maltreatment, Sexual Abuse: A Journal of Research and Treatment. She is the author of many journal articles, book chapters and has edited several books.

MARTHA A. BIRD, MD

Dr. Bird is a Child and Adolescent Psychiatrist in private practice. She has extensive knowledge concerning Attention Deficit Disorder, sexual abuse, and other childhood psychiatric disorders, as well as the use of psychiatric medications in the treatment of children. Dr. Bird has extensive committee experience and served as President of the Washington State Council of Child and Adolescent Psychiatry in 1995-1996.

CHAREE BOULTER, Ph.D

Dr. Boulter has several years experience working with victims of crime, as a therapist and victim advocate. She worked as an advocate for victims of sexual assault and domestic violence as the coordinator of Sexual Assault Services for *Alternatives to Violence of the Palouse*. Previously she worked in the mental health field while pursuing her doctorate in Counseling Psychology. Through experience in both community and university based agencies, Dr. Boulter brings to the task force knowledge of therapeutic issues frequently experienced by victims of crime, psychological assessment, treatment modalities, and social issues for victims.

Dr. Boulter is currently employed as a Counselor/Substance Abuse Prevention Program Coordinator at the University of Puget Sound. She provides psychotherapy for Puget Sound students dealing with a variety of developmental and clinical issues, consultation and outreach to students and staff, coordinates substance abuse prevention programming, and is developing a multidimensional prevention plan based on the *social norms theory*.

CARLOS CARRILLO, M.ED

Mr. Carrillo brings cultural experience and knowledge to his work and diverse experience in providing mental health treatment to victims of sexual abuse. For six years he was a therapist at the Yakima Valley Farm Workers Clinic in Yakima and Toppenish, working with children, adolescent, and adult victims of sexual abuse. The clinic has a special program for Hispanic families. Mr. Carrillo supervised the clinical work provided to clients, as well as providing direct treatment.

He has worked with the Department of Children and Family Services, since October 1995, to provide services to families in crisis, addressing issues related to victimization or abuse of children and teenagers. He is now supervising the adolescent unit, where he often encounters teenage females who were raped or sexually assaulted. Additionally, he facilitates services for juvenile sex offenders.

Mr. Carrillo works with other agencies in the community, primarily with the three mental health agencies dealing with cases of sexual abuse.

JERRY DEVORE, Ph.D.

Since 1987, Dr. DeVore has been the Director of Rehabilitation and Medical Psychology at Good Samaritan Hospital in Puyallup, Washington. Dr. DeVore began his education at Clark Junior College in Vancouver, Washington. He then obtained an A.A. in psychology and completed a B.A. in psychology at Western Washington University, in Bellingham. Dr. DeVore interspersed his education with an enlisted tour of duty in the U.S. Army and Navy. In both services he was a mental health counselor. While in the Navy, stationed in Hawaii, he completed an M.A. in guidance and counseling through the University of Northern Colorado. Prior to his tour in Hawaii, he worked for one year as a Neighborhood Youth Corps Coordinator in Vancouver, Washington. His Ph.D was completed in clinical psychology at the University of St. Louis.

Dr. DeVore's pre-doctoral internship was completed through Dwight David Eisenhower Army Medical Center at Ft. Gordon in Augusta, Georgia. Staying on to complete a post-doctoral year of supervised practice, he became a faculty member of the Clinical Psychology Internship Program in the area of Community Psychology. From 1982 through 1987, Dr. DeVore served as a clinical psychologist for the U.S. Army in the capacity of Chief, Psychology Section, Community Mental Health at Ft. Gordon. He later served as Division Psychologist for the 9th Infantry Division at Ft. Lewis, Washington. He has served in special projects, such as consultant to the Special Reaction Team, Military Police, and consultant to General Sennewald's Suicide Prevention Task Force. In 1998, he was awarded diplomat status by the American Board of Professional Psychologists, in the specialty of clinical psychology.

Dr. DeVore's work focuses on the impact of environmental events, physical trauma and acquired illnesses. As a military psychologist, responsibilities included assisting in development of programs to manage the stress of warfare, guerrilla actions, and terrorism in military and civilian populations. As a rehabilitation and medical psychologist he has focused on the impact of personal injury, particularly in work settings and motor vehicle accidents. In all settings Dr. DeVore has provided assessment and treatment of patients, in addition to conducting program development and performing management responsibilities. His work has also involved treating crime victims injured severely enough to require multidisciplinary rehabilitation services for brain injury and/or spinal cord injury.

LAURA GROSHONG, MA, BCD

Ms. Groshong received her Masters' in Social Work from the University of Chicago, School of Social Service Administration in 1974. In 1979, she received certification from the Seattle Psychoanalytic Institute in Adult Psychotherapy and became a Board Certified diplomat, the highest national level of clinical expertise in social work. Ms. Groshong received her certification as a Social Worker in Washington in 1988.

From 1974 to 1978, she worked at Harborview Medical Center on Inpatient Psychiatry. Ms. Groshong has operated a private practice in Seattle since 1977. Since 1996, she has served as the Legislative Chair for the Washington State Society for Clinical Social Worker. She has also served on the Dissociation/ Dependency Task Force, convened by the Department of Health. Ms. Groshong is a registered lobbyist and has worked in that capacity for the Washington State Coalition of Mental Health Professionals and Consumers Since 1995. In addition, from 1994 to 1997, Ms. Groshong was the National Legislative Chair for the National Membership Committee on Psychoanalysis that represents analytic social workers, and was recently appointed National Legislative co-chair for the Clinical Social Work Federation.

LUCY A. HOMANS, EdD

Dr. Homans is a licensed psychologist in Washington State. In addition to maintaining a private practice, she is the Director of Professional Affairs for the Washington State Psychological Association (WSPA).

Dr. Homans received her graduate degree in counseling psychology from Columbia University in 1982. Prior to attending graduate school, she worked in government in the Office of the Mayor in Boston, and for a U.S. congressperson. She received her undergraduate degree in Political Science from Tufts University.

Dr. Homans is a member of the Board of Trustees of the Puget Sound Blood Center, and former trustee of the King County Crisis Clinic. She is a 1998 recipient of the American Psychological Association Karl F. Heiser award for excellence in public policy, and the 1993 recipient of the Washington State Psychological Association Distinguished Psychologist award.

BARBARA HUFFMAN, MSW

Ms. Huffman is a clinical social worker, family therapist, supervisor and program coordinator with the outpatient child and family division, of a large non-profit mental health agency in Snohomish County, formerly Luther Child Center, now Compass Health.

In her clinical work with children and families, in the past sixteen years, she has provided individual, child and adult, family and group therapies for victims of sexual abuse and assault, as well as other trauma. She is an expert in the field of sexual abuse and provides training, consultation and expert testimony in the field.

In addition to agency work, she provides therapy for adult survivors in her private practice in Everett. She currently holds a seat on the Washington State Sexual Assault Services Advisory Committee.

TIM KELLER, MD, MPH

Dr. Keller served as co-chair of the Crime Victims' Mental Health Treatment Guidelines Task Force and represents the Washington State Medical Society and The Washington State Psychiatric Association. He is currently practicing Psychiatry at the Evergreen Clinic in Kirkland. He was previously the Medical Director at Seattle Mental Health and a Clinical Associate Professor of Psychiatry at the University of Washington. He is also a Psychiatric Consultant for Post-Traumatic Stress Disorder to the Seattle Division of Puget Sound VA Medical Center. He was previously an Attending Psychiatrist to the Post-traumatic Stress Disorder Outpatient Team at the VA medical center. Dr. Keller has organized symposia on, and studied trauma and its aftermath in South Africa and countries of the Middle East. He is the author of many research papers and a book chapter on Post-traumatic Stress Disorder.

Dr. Keller received his medical training at Case Western Reserve University and has a degree in Public Health from the University of California, Berkeley. Dr. Keller is a Fellow of the American Psychiatric Association and Chairman of its Continuing Education Committee. He is the immediate past President of the Washington State Psychiatric Association. Active in the Washington State Medical Association, Washington Physicians for Social Responsibility, and the International Society for Traumatic Stress Studies. Dr. Keller lives in Seattle with his wife and two children.

KARA LAVERDE, MSW

Ms. Laverde is a Training Specialist at The Casey Family Program in Seattle. Previous employment included a position as coordinator of the Providence Health System Family Violence Program. This training program equips medical providers and staff with skills necessary to routinely screen for family violence and provide early intervention.

Ms. Laverde has worked with battered women at several community domestic violence programs and has worked in the area of teen dating violence. She was co-chair of the King County Coalition Against Domestic Violence and served on the Board of Directors for the Program for Early Parent Support (PEPS). She also volunteered with the Asian Pacific Islander Women and Family Safety Center. Ms. Laverde is a certified clinical social worker who received her BA from Smith College and Masters' of Social Work from the University of Washington.

JAMES MAHONEY, MSW

Mr. Mahoney is a Social Worker in private practice in Spokane, Washington and is President of the Washington State Chapter of the National Association of Social Workers. He specializes in working with parents and their children who have experienced early childhood trauma. Mr. Mahoney provides individual, marital and family therapy, as well as group counseling. He also provides consultations, parenting and attachment evaluations and conducts assessments related to juvenile fire setting. Mr. Mahoney provides expert witness testimony in child welfare issues in the inland Northwest and Western Washington. In addition, he has provided forensic social work evaluations for the Spokane County Juvenile Public Defender's office and for Public Defenders throughout the state.

Mr. Mahoney was the Chairperson for the Northside Child Protection Team for eleven years. As an Adjunct Professor, he provides instruction in community development at the School of Social Work and Human Services at Eastern Washington University. He has a home based services contract with Washington State Department of Social and Health Services. He also provides rural and urban based counseling services and family assessments throughout Eastern Washington.

In his work with families of color and white parents raising children of color, Mr. Mahoney has extensively used Gordon Allport's (1954) contact theory of intergroup relations. Allport's theory provides the most studied interventions, designed to reduce racist prejudice, stereotyping and discrimination. Emphasis is placed on the reduction and elimination of racism through equal status

contact between majority and minority groups, in pursuit of common goals. Mr. Mahoney's focus is to remove barriers to effective service delivery to enhance cultural and professional equity. Provider credibility and consumer trust in providers is thus established before consumer contact is made.

Mr. Mahoney is also President of the Inland Empire Rental Association. He has provided training in the Specialist Certificate Program, sponsored by the Washington State Mental Health Division and the Eastern Washington University School of Social Work. This training targets ways that mental health workers can proactively address the housing needs of psychiatrically impaired residents.

Mr. Mahoney has led numerous workshops and seminars in over thirty-five states and four of the Canadian provinces. He advocates a consumer-based model that integrates parental perceptions and participation in the therapy process. His extensive clinical work with adoptive and foster families is widely known for its creativity and results.

TED RYNEARSON, MD

Dr. Rynearson is the Medical Director of the Separation and Loss Services Program at Virginia Mason Medical Center in Seattle. He has extensive experience in providing mental health services dealing with the issue of suicide. He also has expertise dealing with family members of homicide victims. He has taught and held faculty appointments in the Psychiatry Departments at the University of Washington, New Zealand and Australia. Dr. Rynearson has an extensive bibliography of journal articles he has written, dealing with issues of bereavement.

MURIEL TEMPLETON, MS, CMHC

Ms. Templeton is a Certified Mental Health Counselor in private practice in Richland, Washington. She has worked in the area of sexual abuse and assault for over 20 years. She was the Founding Director of the Mid-Columbia Rape Relief Program in 1997, a program of the Mid-Columbia Mental Health Center, which has since evolved into the Richland Sexual Assault Response Center. Ms. Templeton was the founding board member of the Washington Coalition of Sexual Assault Programs (WCSAP).

Prior to private practice, Ms. Templeton worked in the Out-Patient department of the Mid-Columbia Mental Health Center. She specializes in the treatment of sexual abuse and provides training consultation and expert testimony.

She is a former President of the Washington State Mental Health Counselors Association. She is also a member of the Crime Victims' Compensation Program (CVCP) Mental Health Advisory Committee, and a member of the Washington State Sexual Assault Services Advisory Committee.

STEVE ECKSTROM, MSW

Mr. Eckstrom has worked as coordinator of Advocacy Services for the State of Washington, Office of Crime Victims Advocacy in Olympia since October 1990. Prior to assuming that position, he was Director of the Victim/Witness Assistance Unit of the Snohomish County Prosecutor's Office in Everett, Washington for ten years. Mr. Eckstrom was active for several years participating in statewide efforts to strengthen rights and improve services for crime victims. He served as a founding board member and the first Chairperson of the Washington Coalition of Crime Victim Advocates. Before moving to Washington in 1979, Mr. Eckstrom worked for several years as a counselor and program manager in a residential treatment program for juvenile offenders. He received his MSW from the University of Washington in 1981.

BEV EMERY, MA

Ms. Emery is the Executive Administrator for The Office of Crime Victims Advocacy (OCVA). She has 17 years of experience in the field of victims advocacy. She worked for 8 years as the Director of the Washington State Coalition of Sexual Assault Programs. She developed the OCVA, after its establishment in 1990, as a result of the Community Protection Act. Ms. Emery has successfully overseen the growth of OCVA from one main grant program to multiple funding sources, for victims of crime. Some of the sources include, Violence Against Women Act, Youth Violence Prevention, Gang Violence Prevention, Sexual Assault Treatment and Prevention, Court Appointed Special Advocates Program, and the Domestic Violence Legal Advocacy Program. She has also successfully enhanced advocacy services provided by OCVA.

MONICA FITZGERALD, BA

Ms. Fitzgerald graduated cum laude with honors in psychology and a Spanish degree from Tulane University in 1994. Since graduation, she has worked as a counselor in residential treatment centers in Albuquerque, New Mexico and Seattle, Washington with children who are emotionally and behaviorally disturbed. Ms. Fitzgerald has also worked as a research assistant on various projects studying mental health service utilization by crime victims; legal representation for maltreated, dependent children; violence in Navy families; children's memory characteristics for negative and positive events; and, the prevention of child sexual abuse through the investigation of offenders' modus operandi.

Ms. Fitzgerald was employed as the research analyst for the CVCP Mental Health Treatment Guidelines Task Force. She conducted extensive literature searches and reviewed effective treatment interventions for children and adults suffering from the psychological sequelae related to their victimization. Ms. Fitzgerald will begin her graduate studies in the Ph.D. program in clinical psychology at the University of Georgia in the Fall of 1999.

GARY FRANKLIN, MD, MPH

Dr. Franklin obtained his M.D. from George Washington University and an M.P.H from the University of California at Berkeley. He is a board certified neurologist whose current positions are: 1) Research Professor, Department of Environmental Health and Medicine, University of Washington, and 2) Medical Director, Washington State Department of Labor and Industries.

Dr. Franklin's major research interests include use of administrative databases (workers' compensation) to generate epidemiologic research, outcome of medical treatment modalities for occupational musculoskeletal disease, and reliability and validity of currently used impairment rating systems for occupational injury and disease.

ORLANDO MANAOIS, LCSW

Mr. Manaois is a licensed certified Social Worker. He is a consultant and technical assistance specialist in sexual assault trauma (victimization) and mental health services and programming for ethnic minorities, sexual minorities, older adults and deaf/hard of hearing individuals (children and adults). He possesses experience, knowledge and skills in health and human services as a manager and clinician.

Presently with the Department of Social and Health Services' Children's Administration as a Program Manager, Mr. Manaois has responsibility for child sexual abuse and sexually aggressive youth issues and works closely with the Department of Corrections Offender Community Programs Unit. Mr. Manaois is formally associated with the King County Mental Heath Division, Harborview Sexual Assault Center, Evergreen Care Network, Valley Cities Mental Health Center, Echo Glen Children's Center and Ryther Child Center.

CLETUS NNANABU, MBA

Mr. Nnanabu is Program Manager of the Crime Victims' Compensation Program at the Department of Labor and Industries. He has spent the last two and a half years establishing a financially stable, customer friendly program to maintain a more active role in the victim services community. His plan also equates to a closer working relationship with victim/witness coordinators and advocates.

Mr. Nnanabu has spent most of his professional life in customer-service oriented positions. He joined the Department of Social and Health Services (DSHS) in 1978 as a Drug and Alcohol Counselor at Eastern State Hospital, later becoming a Financial Services Technician. He left DSHS to work for the Department of Labor and Industries, first as a Claim Manager, then a Field Auditor, and eventually to a Claims Unit Supervisor, a position he held until his appointment to Program Manager in 1994.

Mr. Nnanabu served as a member of former Governor Lowry's Task Force for Domestic Violence. He has also served on various committees including, the agency's committee to create policy on Domestic Violence and the Workplace, The Violence Against Women Act (VAWA) Committee and the committee for the reorganization of The Department of Labor and Industries. Mr. Nnanabu coaches youth soccer and serves as a member of the Tumwater Soccer's Coach Association. He holds an MBA in finance from Eastern Washington University.

LONI PARR, RN, BA

Ms. Parr is the Occupational Nurse Consultant for the Department of Labor and Industries Crime Victims' Compensation Program.

LAUREN SLOVIC, MSW

Ms. Slovic served as Project Manager for the Department of Labor and Industries Crime Victims' Mental Health Treatment Guidelines Task Force. She is experienced in providing counseling, conducting research, planning and developing programs and policies and providing training to corporate, public sector and private non-profit audiences. Her work has addressed the issues of stress management, domestic and workplace violence, coping with change and transition, and issues related to the elderly and their caregivers.

As an employee of the Polaroid Corporation, she was involved with the development and implementation of innovative approaches to juggling work and elder care responsibilities, and violence prevention and intervention, both in the workplace and in the greater community. While at Polaroid, Ms. Slovic coordinated the Business Partners Against Violence Project, which partnered businesses with battered women's programs.

Ms. Slovic worked with Washington State's former Governor (Mike Lowry) on his Domestic Violence Initiative to develop public sector response to domestic violence in Washington State. She also worked with Jewish Family Service in Seattle to research the extent of domestic violence in the Jewish community and develop a plan for intervention strategies for the Jewish community. She has also consulted for the Family Violence Prevention Fund in San Francisco.

Ms. Slovic has extensive experience leading committees, including serving as co-chair of the Women's Issues Committee for the National Association of Social Workers, Massachusetts Chapter.

HAL STOCKBRIDGE, MD, MPH

Dr. Stockbridge received a Bachelor of Arts from Princeton University in 1979. He attended the University of Cincinnati, College of Medicine receiving a medical degree in 1984. After an internship at the University of Texas and M.D. Anderson Hospital in Houston, Dr. Stockbridge did volunteer work in the Republic of China. After completing his residency in internal medicine, Dr. Stockbridge did a fellowship at the University of Washington and Harborview Medical Center, in Occupational and Environmental Medicine. He received his Master of Public Health in 1990 through the University of Washington. He is board-certified in Internal Medicine and Occupational and Environmental Medicine and Preventive Medicine.

Dr. Stockbridge was appointed Associate Medical Director at the Department of Labor and Industries in 1991. In this position, Dr. Stockbridge is involved in a wide range of issues; including medical policy development and implementation, medical guideline development and implementation, programs and projects aimed at prevention of long- term disability, efforts to improve the management of claims for occupational diseases, such as musculoskeletal conditions and chemically related illness, and efforts to improve the fairness and reliability of doctors' ratings of permanent impairment. Dr. Stockbridge has conducted and participated in original research on a variety of topics, including lead poisoning, Multiple Chemical Sensitivity Syndrome, functional brain imaging, prophyria, assessment of permanent impairment, and prevention of long-term disability.

CAROL WOOD, Ph.D.

Dr. Wood was educated and trained in Southern California. She moved to Seattle in late 1992. Dr. Wood has experience working in social service agencies, community mental health and private practice, and with children, adolescents, adults, couples and families. She has worked with victims of childhood physical and sexual abuse and neglect, battered women and their children, survivors of physical assault and individuals with chronic conditions from injuries sustained through victimization.

Since late March 1997, she has been the Psychologist Consultant to the Crime Victims Compensation Program. In this capacity, she provides education and consultation to the CVCP staff and administration, and has served as the liaison to the clinical community at large. Dr. Wood has a small private practice in North Kitsap County.